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Basic Structure and Function of the Nervous System

By the end of this section, you will be able to:

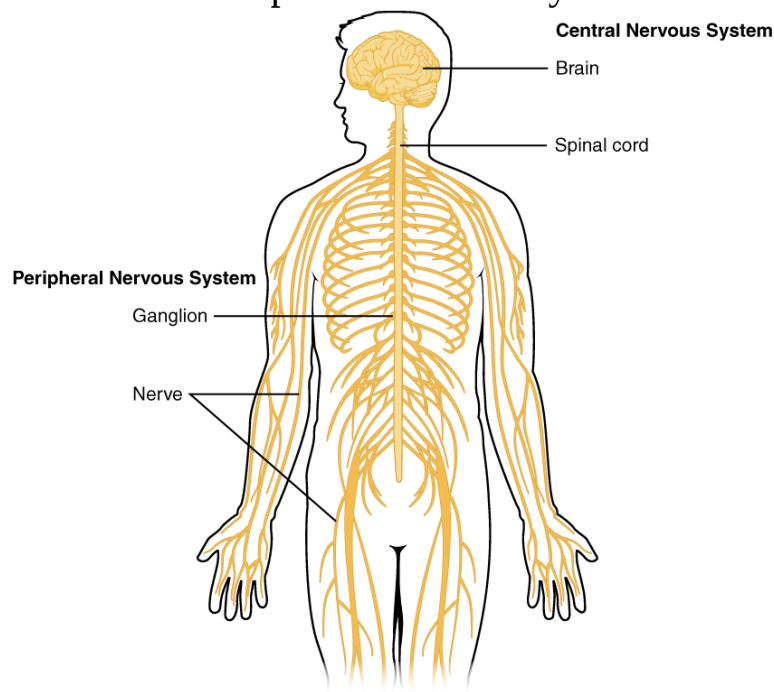
- Identify the anatomical and functional divisions of the nervous system
- Relate the functional and structural differences between gray matter and white matter structures of the nervous system to the structure of neurons
- List the basic functions of the nervous system

The picture you have in your mind of the nervous system probably includes the **brain**, the nervous tissue contained within the cranium, and the **spinal cord**, the extension of nervous tissue within the vertebral column. That suggests it is made of two organs—and you may not even think of the spinal cord as an organ—but the nervous system is a very complex structure. Within the brain, many different and separate regions are responsible for many different and separate functions. It is as if the nervous system is composed of many organs that all look similar and can only be differentiated using tools such as the microscope or electrophysiology. In comparison, it is easy to see that the stomach is different than the esophagus or the liver, so you can imagine the digestive system as a collection of specific organs.

The Central and Peripheral Nervous Systems

The nervous system can be divided into two major regions: the central and peripheral nervous systems. The **central nervous system (CNS)** is the brain and spinal cord, and the **peripheral nervous system (PNS)** is everything else ([\[link\]](#)). The brain is contained within the cranial cavity of the skull, and the spinal cord is contained within the vertebral cavity of the vertebral column. It is a bit of an oversimplification to say that the CNS is what is inside these two cavities and the peripheral nervous system is outside of them, but that is one way to start to think about it. In actuality, there are some elements of the peripheral nervous system that are within the cranial or vertebral cavities. The peripheral nervous system is so named because it is on the periphery—meaning beyond the brain and spinal cord. Depending on different aspects of the nervous system, the dividing line between central and peripheral is not necessarily universal.

Central and Peripheral Nervous System



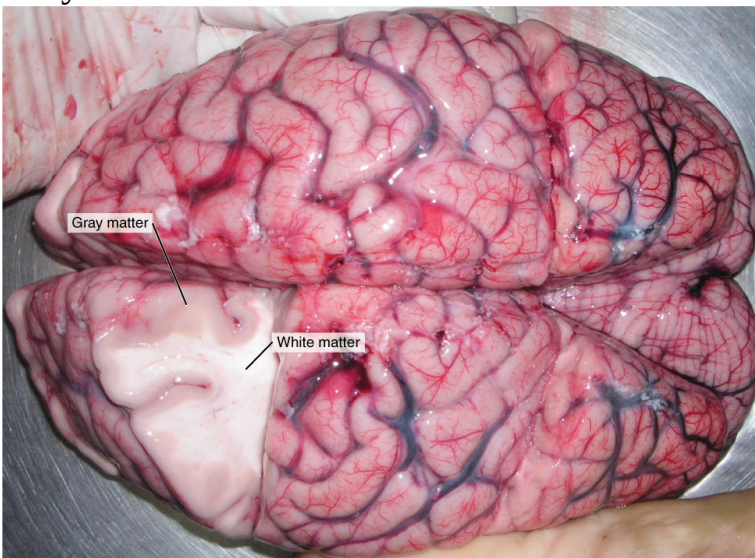
The structures of the PNS are referred to as ganglia and nerves, which can be seen as distinct structures. The equivalent structures in the CNS are not obvious from this overall perspective and are best examined in prepared tissue under the microscope.

Nervous tissue, present in both the CNS and PNS, contains two basic types of cells: neurons and glial cells. A **glial cell** is one of a variety of cells that provide a framework of tissue that supports the neurons and their activities. The **neuron** is the more functionally important of the two, in terms of the communicative function of the nervous system. To describe the functional divisions of the nervous system, it is important to understand the structure of a neuron. Neurons are cells and therefore have a **soma**, or cell body, but they also have extensions of the cell; each extension is generally referred to as a **process**. There is one important process that every neuron has called an **axon**, which is the fiber that connects a neuron with its target. Another type

of process that branches off from the soma is the **dendrite**. Dendrites are responsible for receiving most of the input from other neurons. Looking at nervous tissue, there are regions that predominantly contain cell bodies and regions that are largely composed of just axons. These two regions within nervous system structures are often referred to as **gray matter** (the regions with many cell bodies and dendrites) or **white matter** (the regions with many axons). [\[link\]](#) demonstrates the appearance of these regions in the brain and spinal cord. The colors ascribed to these regions are what would be seen in “fresh,” or unstained, nervous tissue. Gray matter is not necessarily gray. It can be pinkish because of blood content, or even slightly tan, depending on how long the tissue has been preserved. But white matter is white because axons are insulated by a lipid-rich substance called **myelin**. Lipids can appear as white (“fatty”) material, much like the fat on a raw piece of chicken or beef. Actually, gray matter may have that color ascribed to it because next to the white matter, it is just darker—hence, gray.

The distinction between gray matter and white matter is most often applied to central nervous tissue, which has large regions that can be seen with the unaided eye. When looking at peripheral structures, often a microscope is used and the tissue is stained with artificial colors. That is not to say that central nervous tissue cannot be stained and viewed under a microscope, but unstained tissue is most likely from the CNS—for example, a frontal section of the brain or cross section of the spinal cord.

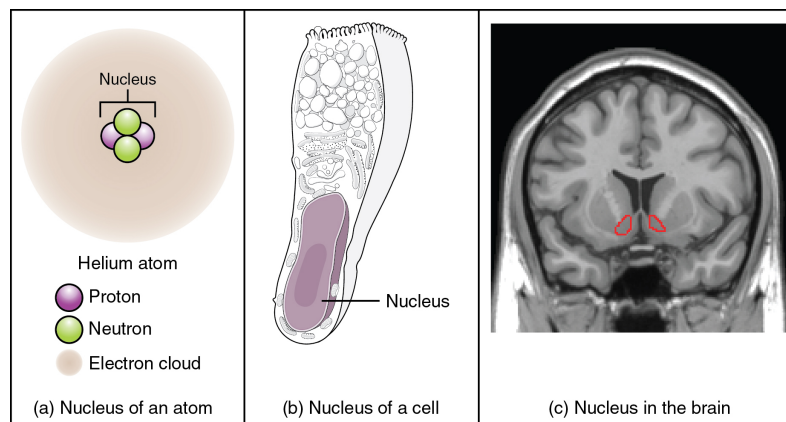
Gray Matter and White Matter



A brain removed during an autopsy, with a partial section removed, shows white matter surrounded by gray matter. Gray matter makes up the outer cortex of the brain. (credit: modification of work by “Suseno”/Wikimedia Commons)

Regardless of the appearance of stained or unstained tissue, the cell bodies of neurons or axons can be located in discrete anatomical structures that need to be named. Those names are specific to whether the structure is central or peripheral. A localized collection of neuron cell bodies in the CNS is referred to as a **nucleus**. In the PNS, a cluster of neuron cell bodies is referred to as a **ganglion**. [\[link\]](#) indicates how the term nucleus has a few different meanings within anatomy and physiology. It is the center of an atom, where protons and neutrons are found; it is the center of a cell, where the DNA is found; and it is a center of some function in the CNS. There is also a potentially confusing use of the word ganglion (plural = ganglia) that has a historical explanation. In the central nervous system, there is a group of nuclei that are connected together and were once called the basal ganglia before “ganglion” became accepted as a description for a peripheral structure. Some sources refer to this group of nuclei as the “basal nuclei” to avoid confusion.

What Is a Nucleus?

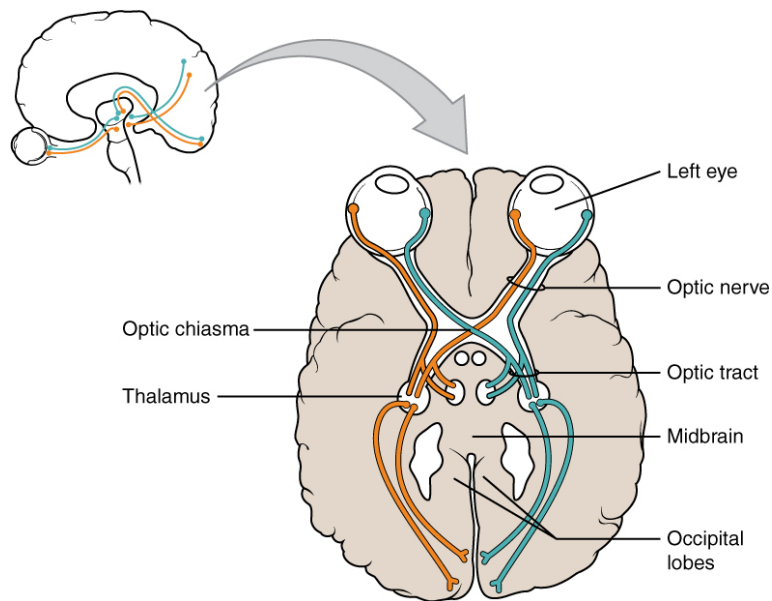


(a) The nucleus of an atom contains its

protons and neutrons. (b) The nucleus of a cell is the organelle that contains DNA. (c) A nucleus in the CNS is a localized center of function with the cell bodies of several neurons, shown here circled in red. (credit c: “Was a bee”/Wikimedia Commons)

Terminology applied to bundles of axons also differs depending on location. A bundle of axons, or fibers, found in the CNS is called a **tract** whereas the same thing in the PNS would be called a **nerve**. There is an important point to make about these terms, which is that they can both be used to refer to the same bundle of axons. When those axons are in the PNS, the term is nerve, but if they are CNS, the term is tract. The most obvious example of this is the axons that project from the retina into the brain. Those axons are called the optic nerve as they leave the eye, but when they are inside the cranium, they are referred to as the optic tract. There is a specific place where the name changes, which is the optic chiasm, but they are still the same axons ([\[link\]](#)). A similar situation outside of science can be described for some roads. Imagine a road called “Broad Street” in a town called “Anyville.” The road leaves Anyville and goes to the next town over, called “Hometown.” When the road crosses the line between the two towns and is in Hometown, its name changes to “Main Street.” That is the idea behind the naming of the retinal axons. In the PNS, they are called the optic nerve, and in the CNS, they are the optic tract. [\[link\]](#) helps to clarify which of these terms apply to the central or peripheral nervous systems.

Optic Nerve Versus Optic Tract



This drawing of the connections of the eye to the brain shows the optic nerve extending from the eye to the chiasm, where the structure continues as the optic tract. The same axons extend from the eye to the brain through these two bundles of fibers, but the chiasm represents the border between peripheral and central.

Note:



In 2003, the Nobel Prize in Physiology or Medicine was awarded to Paul C. Lauterbur and Sir Peter Mansfield for discoveries related to magnetic

resonance imaging (MRI). This is a tool to see the structures of the body (not just the nervous system) that depends on magnetic fields associated with certain atomic nuclei. The utility of this technique in the nervous system is that fat tissue and water appear as different shades between black and white. Because white matter is fatty (from myelin) and gray matter is not, they can be easily distinguished in MRI images. Visit the Nobel Prize [web site](#) to play an interactive game that demonstrates the use of this technology and compares it with other types of imaging technologies. Also, the results from an MRI session are compared with images obtained from X-ray or computed tomography. How do the imaging techniques shown in this game indicate the separation of white and gray matter compared with the freshly dissected tissue shown earlier?

Structures of the CNS and PNS		
	CNS	PNS
Group of Neuron Cell Bodies (i.e., gray matter)	Nucleus	Ganglion
Bundle of Axons (i.e., white matter)	Tract	Nerve

Functional Divisions of the Nervous System

The nervous system can also be divided on the basis of its functions, but anatomical divisions and functional divisions are different. The CNS and the PNS both contribute to the same functions, but those functions can be attributed to different regions of the brain (such as the cerebral cortex or the hypothalamus) or to different ganglia in the periphery. The problem with trying to fit functional differences into anatomical divisions is that sometimes the same structure can be part of several functions. For example,

the optic nerve carries signals from the retina that are either used for the conscious perception of visual stimuli, which takes place in the cerebral cortex, or for the reflexive responses of smooth muscle tissue that are processed through the hypothalamus.

There are two ways to consider how the nervous system is divided functionally. First, the basic functions of the nervous system are sensation, integration, and response. Secondly, control of the body can be somatic or autonomic—divisions that are largely defined by the structures that are involved in the response. There is also a region of the peripheral nervous system that is called the enteric nervous system that is responsible for a specific set of the functions within the realm of autonomic control related to gastrointestinal functions.

Basic Functions

The nervous system is involved in receiving information about the environment around us (sensation) and generating responses to that information (motor responses). The nervous system can be divided into regions that are responsible for **sensation** (sensory functions) and for the **response** (motor functions). But there is a third function that needs to be included. Sensory input needs to be integrated with other sensations, as well as with memories, emotional state, or learning (cognition). Some regions of the nervous system are termed **integration** or association areas. The process of integration combines sensory perceptions and higher cognitive functions such as memories, learning, and emotion to produce a response.

Sensation. The first major function of the nervous system is sensation—receiving information about the environment to gain input about what is happening outside the body (or, sometimes, within the body). The sensory functions of the nervous system register the presence of a change from homeostasis or a particular event in the environment, known as a **stimulus**. The senses we think of most are the “big five”: taste, smell, touch, sight, and hearing. The stimuli for taste and smell are both chemical substances (molecules, compounds, ions, etc.), touch is physical or mechanical stimuli that interact with the skin, sight is light stimuli, and hearing is the

perception of sound, which is a physical stimulus similar to some aspects of touch. There are actually more senses than just those, but that list represents the major senses. Those five are all senses that receive stimuli from the outside world, and of which there is conscious perception. Additional sensory stimuli might be from the internal environment (inside the body), such as the stretch of an organ wall or the concentration of certain ions in the blood.

Response. The nervous system produces a response on the basis of the stimuli perceived by sensory structures. An obvious response would be the movement of muscles, such as withdrawing a hand from a hot stove, but there are broader uses of the term. The nervous system can cause the contraction of all three types of muscle tissue. For example, skeletal muscle contracts to move the skeleton, cardiac muscle is influenced as heart rate increases during exercise, and smooth muscle contracts as the digestive system moves food along the digestive tract. Responses also include the neural control of glands in the body as well, such as the production and secretion of sweat by the eccrine and merocrine sweat glands found in the skin to lower body temperature.

Responses can be divided into those that are voluntary or conscious (contraction of skeletal muscle) and those that are involuntary (contraction of smooth muscles, regulation of cardiac muscle, activation of glands). Voluntary responses are governed by the somatic nervous system and involuntary responses are governed by the autonomic nervous system, which are discussed in the next section.

Integration. Stimuli that are received by sensory structures are communicated to the nervous system where that information is processed. This is called integration. Stimuli are compared with, or integrated with, other stimuli, memories of previous stimuli, or the state of a person at a particular time. This leads to the specific response that will be generated. Seeing a baseball pitched to a batter will not automatically cause the batter to swing. The trajectory of the ball and its speed will need to be considered. Maybe the count is three balls and one strike, and the batter wants to let this pitch go by in the hope of getting a walk to first base. Or maybe the batter's team is so far ahead, it would be fun to just swing away.

Controlling the Body

The nervous system can be divided into two parts mostly on the basis of a functional difference in responses. The **somatic nervous system (SNS)** is responsible for conscious perception and voluntary motor responses.

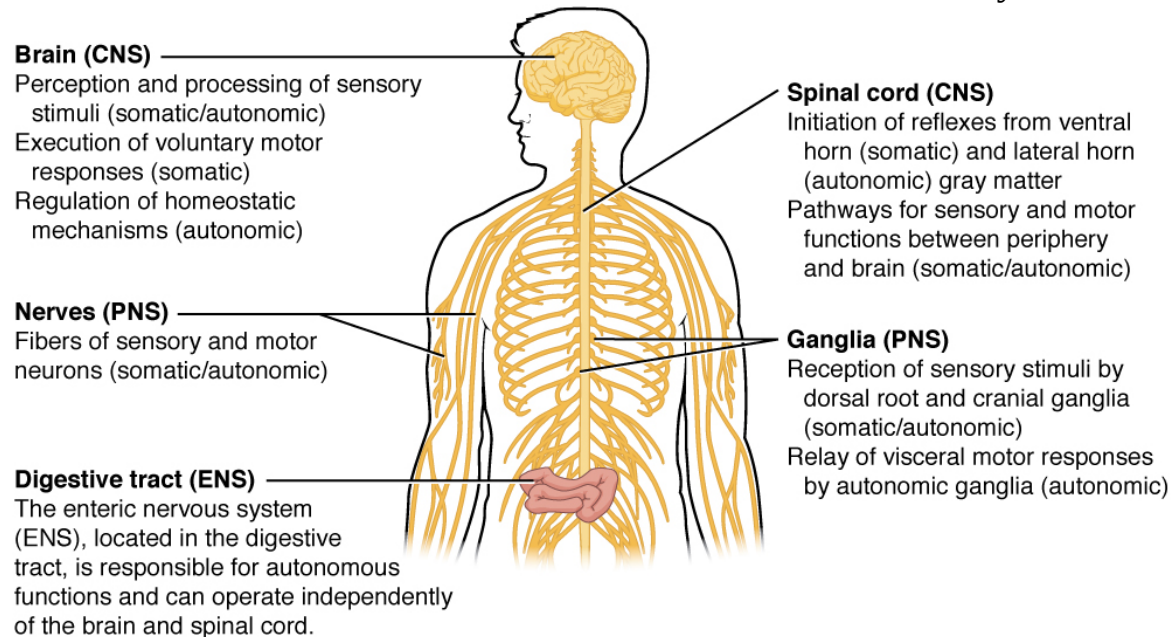
Voluntary motor response means the contraction of skeletal muscle, but those contractions are not always voluntary in the sense that you have to want to perform them. Some somatic motor responses are reflexes, and often happen without a conscious decision to perform them. If your friend jumps out from behind a corner and yells “Boo!” you will be startled and you might scream or leap back. You didn’t decide to do that, and you may not have wanted to give your friend a reason to laugh at your expense, but it is a reflex involving skeletal muscle contractions. Other motor responses become automatic (in other words, unconscious) as a person learns motor skills (referred to as “habit learning” or “procedural memory”).

The **autonomic nervous system (ANS)** is responsible for involuntary control of the body, usually for the sake of homeostasis (regulation of the internal environment). Sensory input for autonomic functions can be from sensory structures tuned to external or internal environmental stimuli. The motor output extends to smooth and cardiac muscle as well as glandular tissue. The role of the autonomic system is to regulate the organ systems of the body, which usually means to control homeostasis. Sweat glands, for example, are controlled by the autonomic system. When you are hot, sweating helps cool your body down. That is a homeostatic mechanism. But when you are nervous, you might start sweating also. That is not homeostatic, it is the physiological response to an emotional state.

There is another division of the nervous system that describes functional responses. The **enteric nervous system (ENS)** is responsible for controlling the smooth muscle and glandular tissue in your digestive system. It is a large part of the PNS, and is not dependent on the CNS. It is sometimes valid, however, to consider the enteric system to be a part of the autonomic system because the neural structures that make up the enteric system are a component of the autonomic output that regulates digestion. There are some differences between the two, but for our purposes here there

will be a good bit of overlap. See [\[link\]](#) for examples of where these divisions of the nervous system can be found.

Somatic, Autonomic, and Enteric Structures of the Nervous System



Somatic structures include the spinal nerves, both motor and sensory fibers, as well as the sensory ganglia (posterior root ganglia and cranial nerve ganglia). Autonomic structures are found in the nerves also, but include the sympathetic and parasympathetic ganglia. The enteric nervous system includes the nervous tissue within the organs of the digestive tract.

Note:



Visit this [site](#) to read about a woman that notices that her daughter is having trouble walking up the stairs. This leads to the discovery of a hereditary condition that affects the brain and spinal cord. The electromyography and MRI tests indicated deficiencies in the spinal cord and cerebellum, both of which are responsible for controlling coordinated movements. To what functional division of the nervous system would these structures belong?

Note:

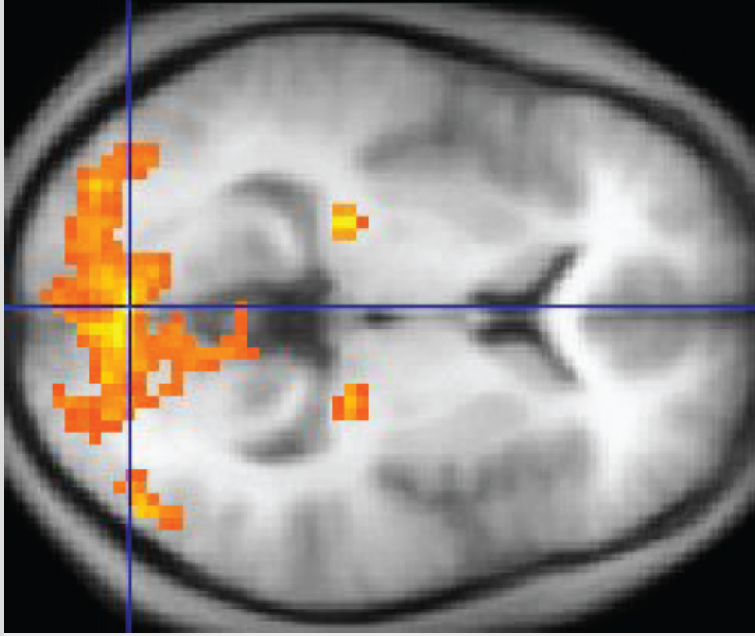
Everyday Connection

How Much of Your Brain Do You Use?

Have you ever heard the claim that humans only use 10 percent of their brains? Maybe you have seen an advertisement on a website saying that there is a secret to unlocking the full potential of your mind—as if there were 90 percent of your brain sitting idle, just waiting for you to use it. If you see an ad like that, don't click. It isn't true.

An easy way to see how much of the brain a person uses is to take measurements of brain activity while performing a task. An example of this kind of measurement is functional magnetic resonance imaging (fMRI), which generates a map of the most active areas and can be generated and presented in three dimensions ([\[link\]](#)). This procedure is different from the standard MRI technique because it is measuring changes in the tissue in time with an experimental condition or event.

fMRI



This fMRI shows activation of the visual cortex in response to visual stimuli.
(credit: "Superborsuk"/Wikimedia Commons)

The underlying assumption is that active nervous tissue will have greater blood flow. By having the subject perform a visual task, activity all over the brain can be measured. Consider this possible experiment: the subject is told to look at a screen with a black dot in the middle (a fixation point). A photograph of a face is projected on the screen away from the center. The subject has to look at the photograph and decipher what it is. The subject has been instructed to push a button if the photograph is of someone they recognize. The photograph might be of a celebrity, so the subject would press the button, or it might be of a random person unknown to the subject, so the subject would not press the button.

In this task, visual sensory areas would be active, integrating areas would be active, motor areas responsible for moving the eyes would be active, and motor areas for pressing the button with a finger would be active. Those areas are distributed all around the brain and the fMRI images would show activity in more than just 10 percent of the brain (some evidence suggests that about 80 percent of the brain is using energy—

based on blood flow to the tissue—during well-defined tasks similar to the one suggested above). This task does not even include all of the functions the brain performs. There is no language response, the body is mostly lying still in the MRI machine, and it does not consider the autonomic functions that would be ongoing in the background.

Chapter Review

The nervous system can be separated into divisions on the basis of anatomy and physiology. The anatomical divisions are the central and peripheral nervous systems. The CNS is the brain and spinal cord. The PNS is everything else. Functionally, the nervous system can be divided into those regions that are responsible for sensation, those that are responsible for integration, and those that are responsible for generating responses. All of these functional areas are found in both the central and peripheral anatomy.

Considering the anatomical regions of the nervous system, there are specific names for the structures within each division. A localized collection of neuron cell bodies is referred to as a nucleus in the CNS and as a ganglion in the PNS. A bundle of axons is referred to as a tract in the CNS and as a nerve in the PNS. Whereas nuclei and ganglia are specifically in the central or peripheral divisions, axons can cross the boundary between the two. A single axon can be part of a nerve and a tract. The name for that specific structure depends on its location.

Nervous tissue can also be described as gray matter and white matter on the basis of its appearance in unstained tissue. These descriptions are more often used in the CNS. Gray matter is where nuclei are found and white matter is where tracts are found. In the PNS, ganglia are basically gray matter and nerves are white matter.

The nervous system can also be divided on the basis of how it controls the body. The somatic nervous system (SNS) is responsible for functions that result in moving skeletal muscles. Any sensory or integrative functions that result in the movement of skeletal muscle would be considered somatic. The autonomic nervous system (ANS) is responsible for functions that

affect cardiac or smooth muscle tissue, or that cause glands to produce their secretions. Autonomic functions are distributed between central and peripheral regions of the nervous system. The sensations that lead to autonomic functions can be the same sensations that are part of initiating somatic responses. Somatic and autonomic integrative functions may overlap as well.

A special division of the nervous system is the enteric nervous system, which is responsible for controlling the digestive organs. Parts of the autonomic nervous system overlap with the enteric nervous system. The enteric nervous system is exclusively found in the periphery because it is the nervous tissue in the organs of the digestive system.

Interactive Link Questions

Exercise:

Problem:

In 2003, the Nobel Prize in Physiology or Medicine was awarded to Paul C. Lauterbur and Sir Peter Mansfield for discoveries related to magnetic resonance imaging (MRI). This is a tool to see the structures of the body (not just the nervous system) that depends on magnetic fields associated with certain atomic nuclei. The utility of this technique in the nervous system is that fat tissue and water appear as different shades between black and white. Because white matter is fatty (from myelin) and gray matter is not, they can be easily distinguished in MRI images. Visit the Nobel Prize [website](#) to play an interactive game that demonstrates the use of this technology and compares it with other types of imaging technologies. Also, the results from an MRI session are compared with images obtained from x-ray or computed tomography. How do the imaging techniques shown in this game indicate the separation of white and gray matter compared with the freshly dissected tissue shown earlier?

Solution:

MRI uses the relative amount of water in tissue to distinguish different areas, so gray and white matter in the nervous system can be seen clearly in these images.

Exercise:

Problem:

Visit this [site](#) to read about a woman that notices that her daughter is having trouble walking up the stairs. This leads to the discovery of a hereditary condition that affects the brain and spinal cord. The electromyography and MRI tests indicated deficiencies in the spinal cord and cerebellum, both of which are responsible for controlling coordinated movements. To what functional division of the nervous system would these structures belong?

Solution:

They are part of the somatic nervous system, which is responsible for voluntary movements such as walking or climbing the stairs.

Review Questions

Exercise:

Problem:

Which of the following cavities contains a component of the central nervous system?

- a. abdominal
- b. pelvic
- c. cranial
- d. thoracic

Solution:

C

Exercise:

Problem:

Which structure predominates in the white matter of the brain?

- a. myelinated axons
- b. neuronal cell bodies
- c. ganglia of the parasympathetic nerves
- d. bundles of dendrites from the enteric nervous system

Solution:

A

Exercise:

Problem:

Which part of a neuron transmits an electrical signal to a target cell?

- a. dendrites
- b. soma
- c. cell body
- d. axon

Solution:

D

Exercise:

Problem:

Which term describes a bundle of axons in the peripheral nervous system?

- a. nucleus
- b. ganglion

- c. tract
- d. nerve

Solution:

D

Exercise:

Problem:

Which functional division of the nervous system would be responsible for the physiological changes seen during exercise (e.g., increased heart rate and sweating)?

- a. somatic
- b. autonomic
- c. enteric
- d. central

Solution:

B

Critical Thinking Questions

Exercise:

Problem:

What responses are generated by the nervous system when you run on a treadmill? Include an example of each type of tissue that is under nervous system control.

Solution:

Running on a treadmill involves contraction of the skeletal muscles in the legs, increase in contraction of the cardiac muscle of the heart, and the production and secretion of sweat in the skin to stay cool.

Exercise:

Problem:

When eating food, what anatomical and functional divisions of the nervous system are involved in the perceptual experience?

Solution:

The sensation of taste associated with eating is sensed by nerves in the periphery that are involved in sensory and somatic functions.

References

Kramer, PD. Listening to prozac. 1st ed. New York (NY): Penguin Books; 1993.

Glossary

autonomic nervous system (ANS)

functional division of the nervous system that is responsible for homeostatic reflexes that coordinate control of cardiac and smooth muscle, as well as glandular tissue

axon

single process of the neuron that carries an electrical signal (action potential) away from the cell body toward a target cell

brain

the large organ of the central nervous system composed of white and gray matter, contained within the cranium and continuous with the spinal cord

central nervous system (CNS)

anatomical division of the nervous system located within the cranial and vertebral cavities, namely the brain and spinal cord

dendrite

one of many branchlike processes that extends from the neuron cell body and functions as a contact for incoming signals (synapses) from other neurons or sensory cells

enteric nervous system (ENS)

neural tissue associated with the digestive system that is responsible for nervous control through autonomic connections

ganglion

localized collection of neuron cell bodies in the peripheral nervous system

glial cell

one of the various types of neural tissue cells responsible for maintenance of the tissue, and largely responsible for supporting neurons

gray matter

regions of the nervous system containing cell bodies of neurons with few or no myelinated axons; actually may be more pink or tan in color, but called gray in contrast to white matter

integration

nervous system function that combines sensory perceptions and higher cognitive functions (memories, learning, emotion, etc.) to produce a response

myelin

lipid-rich insulating substance surrounding the axons of many neurons, allowing for faster transmission of electrical signals

nerve

cord-like bundle of axons located in the peripheral nervous system that transmits sensory input and response output to and from the central

nervous system

neuron

neural tissue cell that is primarily responsible for generating and propagating electrical signals into, within, and out of the nervous system

nucleus

in the nervous system, a localized collection of neuron cell bodies that are functionally related; a “center” of neural function

peripheral nervous system (PNS)

anatomical division of the nervous system that is largely outside the cranial and vertebral cavities, namely all parts except the brain and spinal cord

process

in cells, an extension of a cell body; in the case of neurons, this includes the axon and dendrites

response

nervous system function that causes a target tissue (muscle or gland) to produce an event as a consequence to stimuli

sensation

nervous system function that receives information from the environment and translates it into the electrical signals of nervous tissue

soma

in neurons, that portion of the cell that contains the nucleus; the cell body, as opposed to the cell processes (axons and dendrites)

somatic nervous system (SNS)

functional division of the nervous system that is concerned with conscious perception, voluntary movement, and skeletal muscle reflexes

spinal cord

organ of the central nervous system found within the vertebral cavity and connected with the periphery through spinal nerves; mediates reflex behaviors

stimulus

an event in the external or internal environment that registers as activity in a sensory neuron

tract

bundle of axons in the central nervous system having the same function and point of origin

white matter

regions of the nervous system containing mostly myelinated axons, making the tissue appear white because of the high lipid content of myelin

Nervous Tissue

By the end of this section, you will be able to:

- Describe the basic structure of a neuron
- Identify the different types of neurons on the basis of polarity
- List the glial cells of the CNS and describe their function
- List the glial cells of the PNS and describe their function

Nervous tissue is composed of two types of cells, neurons and glial cells. Neurons are the primary type of cell that most anyone associates with the nervous system. They are responsible for the computation and communication that the nervous system provides. They are electrically active and release chemical signals to target cells. Glial cells, or glia, are known to play a supporting role for nervous tissue. Ongoing research pursues an expanded role that glial cells might play in signaling, but neurons are still considered the basis of this function. Neurons are important, but without glial support they would not be able to perform their function.

Neurons

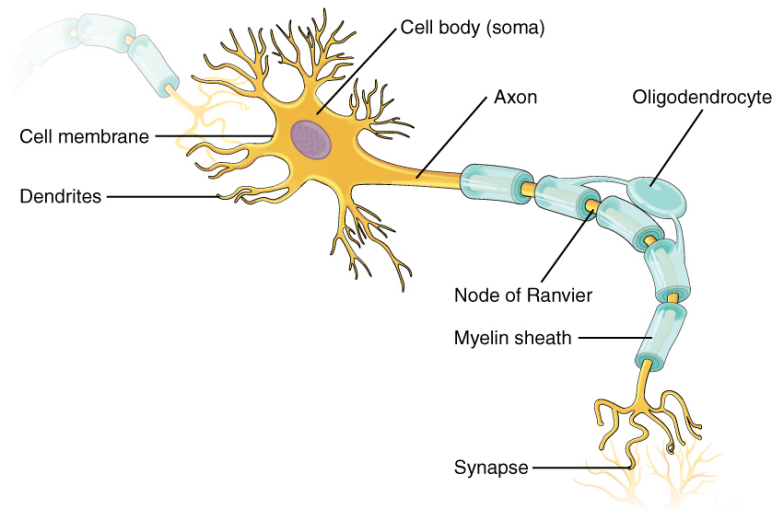
Neurons are the cells considered to be the basis of nervous tissue. They are responsible for the electrical signals that communicate information about sensations, and that produce movements in response to those stimuli, along with inducing thought processes within the brain. An important part of the function of neurons is in their structure, or shape. The three-dimensional shape of these cells makes the immense numbers of connections within the nervous system possible.

Parts of a Neuron

As you learned in the first section, the main part of a neuron is the cell body, which is also known as the soma (soma = “body”). The cell body contains the nucleus and most of the major organelles. But what makes neurons special is that they have many extensions of their cell membranes, which are generally referred to as processes. Neurons are usually described

as having one, and only one, axon—a fiber that emerges from the cell body and projects to target cells. That single axon can branch repeatedly to communicate with many target cells. It is the axon that propagates the nerve impulse, which is communicated to one or more cells. The other processes of the neuron are dendrites, which receive information from other neurons at specialized areas of contact called **synapses**. The dendrites are usually highly branched processes, providing locations for other neurons to communicate with the cell body. Information flows through a neuron from the dendrites, across the cell body, and down the axon. This gives the neuron a polarity—meaning that information flows in this one direction. [\[link\]](#) shows the relationship of these parts to one another.

Parts of a Neuron



The major parts of the neuron are labeled on a multipolar neuron from the CNS.

Where the axon emerges from the cell body, there is a special region referred to as the **axon hillock**. This is a tapering of the cell body toward the axon fiber. Within the axon hillock, the cytoplasm changes to a solution of limited components called **axoplasm**. Because the axon hillock represents the beginning of the axon, it is also referred to as the **initial segment**.

Many axons are wrapped by an insulating substance called myelin, which is actually made from glial cells. Myelin acts as insulation much like the plastic or rubber that is used to insulate electrical wires. A key difference between myelin and the insulation on a wire is that there are gaps in the myelin covering of an axon. Each gap is called a **node of Ranvier** and is important to the way that electrical signals travel down the axon. The length of the axon between each gap, which is wrapped in myelin, is referred to as an **axon segment**. At the end of the axon is the **axon terminal**, where there are usually several branches extending toward the target cell, each of which ends in an enlargement called a **synaptic end bulb**. These bulbs are what make the connection with the target cell at the synapse.

Note:



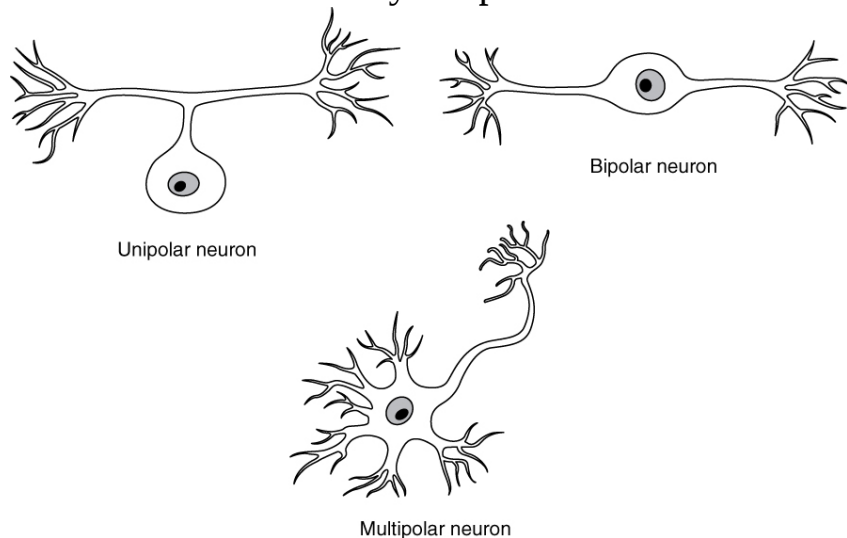
Visit this [site](#) to learn about how nervous tissue is composed of neurons and glial cells. Neurons are dynamic cells with the ability to make a vast number of connections, to respond incredibly quickly to stimuli, and to initiate movements on the basis of those stimuli. They are the focus of intense research because failures in physiology can lead to devastating illnesses. Why are neurons only found in animals? Based on what this article says about neuron function, why wouldn't they be helpful for plants or microorganisms?

Types of Neurons

There are many neurons in the nervous system—a number in the trillions. And there are many different types of neurons. They can be classified by many different criteria. The first way to classify them is by the number of

processes attached to the cell body. Using the standard model of neurons, one of these processes is the axon, and the rest are dendrites. Because information flows through the neuron from dendrites or cell bodies toward the axon, these names are based on the neuron's polarity ([\[link\]](#)).

Neuron Classification by Shape



Unipolar cells have one process that includes both the axon and dendrite. Bipolar cells have two processes, the axon and a dendrite.

Multipolar cells have more than two processes, the axon and two or more dendrites.

Unipolar cells have only one process emerging from the cell. True unipolar cells are only found in invertebrate animals, so the unipolar cells in humans are more appropriately called “pseudo-unipolar” cells. Invertebrate unipolar cells do not have dendrites. Human unipolar cells have an axon that emerges from the cell body, but it splits so that the axon can extend along a very long distance. At one end of the axon are dendrites, and at the other end, the axon forms synaptic connections with a target. Unipolar cells are exclusively sensory neurons and have two unique characteristics. First, their dendrites are receiving sensory information, sometimes directly from the stimulus itself. Secondly, the cell bodies of unipolar neurons are always found in ganglia. Sensory reception is a peripheral function (those dendrites

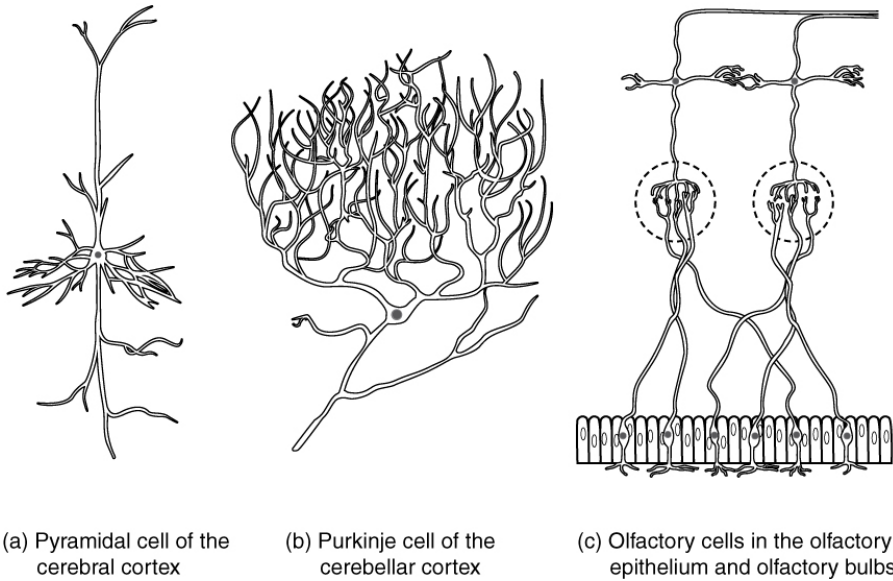
are in the periphery, perhaps in the skin) so the cell body is in the periphery, though closer to the CNS in a ganglion. The axon projects from the dendrite endings, past the cell body in a ganglion, and into the central nervous system.

Bipolar cells have two processes, which extend from each end of the cell body, opposite to each other. One is the axon and one the dendrite. Bipolar cells are not very common. They are found mainly in the olfactory epithelium (where smell stimuli are sensed), and as part of the retina.

Multipolar neurons are all of the neurons that are not unipolar or bipolar. They have one axon and two or more dendrites (usually many more). With the exception of the unipolar sensory ganglion cells, and the two specific bipolar cells mentioned above, all other neurons are multipolar. Some cutting edge research suggests that certain neurons in the CNS do not conform to the standard model of “one, and only one” axon. Some sources describe a fourth type of neuron, called an anaxonic neuron. The name suggests that it has no axon (an- = “without”), but this is not accurate. Anaxonic neurons are very small, and if you look through a microscope at the standard resolution used in histology (approximately 400X to 1000X total magnification), you will not be able to distinguish any process specifically as an axon or a dendrite. Any of those processes can function as an axon depending on the conditions at any given time. Nevertheless, even if they cannot be easily seen, and one specific process is definitively the axon, these neurons have multiple processes and are therefore multipolar.

Neurons can also be classified on the basis of where they are found, who found them, what they do, or even what chemicals they use to communicate with each other. Some neurons referred to in this section on the nervous system are named on the basis of those sorts of classifications ([\[link\]](#)). For example, a multipolar neuron that has a very important role to play in a part of the brain called the cerebellum is known as a Purkinje (commonly pronounced per-KIN-gee) cell. It is named after the anatomist who discovered it (Jan Evangelista Purkinje, 1787–1869).

Other Neuron Classifications



Three examples of neurons that are classified on the basis of other criteria. (a) The pyramidal cell is a multipolar cell with a cell body that is shaped something like a pyramid. (b) The Purkinje cell in the cerebellum was named after the scientist who originally described it. (c) Olfactory neurons are named for the functional group with which they belong.

Glial Cells

Glial cells, or neuroglia or simply glia, are the other type of cell found in nervous tissue. They are considered to be supporting cells, and many functions are directed at helping neurons complete their function for communication. The name glia comes from the Greek word that means “glue,” and was coined by the German pathologist Rudolph Virchow, who wrote in 1856: “This connective substance, which is in the brain, the spinal cord, and the special sense nerves, is a kind of glue (neuroglia) in which the nervous elements are planted.” Today, research into nervous tissue has shown that there are many deeper roles that these cells play. And research may find much more about them in the future.

There are six types of glial cells. Four of them are found in the CNS and two are found in the PNS. [\[link\]](#) outlines some common characteristics and functions.

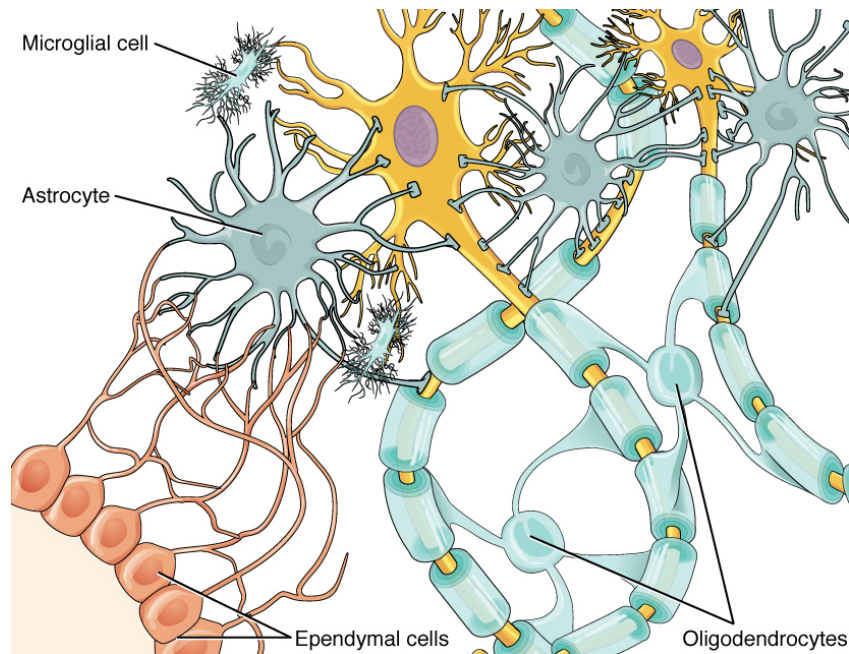
Glial Cell Types by Location and Basic Function		
CNS glia	PNS glia	Basic function
Astrocyte	Satellite cell	Support
Oligodendrocyte	Schwann cell	Insulation, myelination
Microglia	-	Immune surveillance and phagocytosis
Ependymal cell	-	Creating CSF

Glial Cells of the CNS

One cell providing support to neurons of the CNS is the **astrocyte**, so named because it appears to be star-shaped under the microscope (astro- = “star”). Astrocytes have many processes extending from their main cell body (not axons or dendrites like neurons, just cell extensions). Those processes extend to interact with neurons, blood vessels, or the connective tissue covering the CNS that is called the pia mater ([\[link\]](#)). Generally, they are supporting cells for the neurons in the central nervous system. Some ways in which they support neurons in the central nervous system are by maintaining the concentration of chemicals in the extracellular space,

removing excess signaling molecules, reacting to tissue damage, and contributing to the **blood-brain barrier (BBB)**. The blood-brain barrier is a physiological barrier that keeps many substances that circulate in the rest of the body from getting into the central nervous system, restricting what can cross from circulating blood into the CNS. Nutrient molecules, such as glucose or amino acids, can pass through the BBB, but other molecules cannot. This actually causes problems with drug delivery to the CNS. Pharmaceutical companies are challenged to design drugs that can cross the BBB as well as have an effect on the nervous system.

Glial Cells of the CNS



The CNS has astrocytes, oligodendrocytes, microglia, and ependymal cells that support the neurons of the CNS in several ways.

Like a few other parts of the body, the brain has a privileged blood supply. Very little can pass through by diffusion. Most substances that cross the wall of a blood vessel into the CNS must do so through an active transport process. Because of this, only specific types of molecules can enter the CNS. Glucose—the primary energy source—is allowed, as are amino acids. Water and some other small particles, like gases and ions, can enter. But

most everything else cannot, including white blood cells, which are one of the body's main lines of defense. While this barrier protects the CNS from exposure to toxic or pathogenic substances, it also keeps out the cells that could protect the brain and spinal cord from disease and damage. The BBB also makes it harder for pharmaceuticals to be developed that can affect the nervous system. Aside from finding efficacious substances, the means of delivery is also crucial.

Also found in CNS tissue is the **oligodendrocyte**, sometimes called just "oligo," which is the glial cell type that insulates axons in the CNS. The name means "cell of a few branches" (oligo- = "few"; dendro- = "branches"; -cyte = "cell"). There are a few processes that extend from the cell body. Each one reaches out and surrounds an axon to insulate it in myelin. One oligodendrocyte will provide the myelin for multiple axon segments, either for the same axon or for separate axons. The function of myelin will be discussed below.

Microglia are, as the name implies, smaller than most of the other glial cells. Ongoing research into these cells, although not entirely conclusive, suggests that they may originate as white blood cells, called macrophages, that become part of the CNS during early development. While their origin is not conclusively determined, their function is related to what macrophages do in the rest of the body. When macrophages encounter diseased or damaged cells in the rest of the body, they ingest and digest those cells or the pathogens that cause disease. Microglia are the cells in the CNS that can do this in normal, healthy tissue, and they are therefore also referred to as CNS-resident macrophages.

The **ependymal cell** is a glial cell that filters blood to make **cerebrospinal fluid (CSF)**, the fluid that circulates through the CNS. Because of the privileged blood supply inherent in the BBB, the extracellular space in nervous tissue does not easily exchange components with the blood. Ependymal cells line each **ventricle**, one of four central cavities that are remnants of the hollow center of the neural tube formed during the embryonic development of the brain. The **choroid plexus** is a specialized structure in the ventricles where ependymal cells come in contact with blood vessels and filter and absorb components of the blood to produce

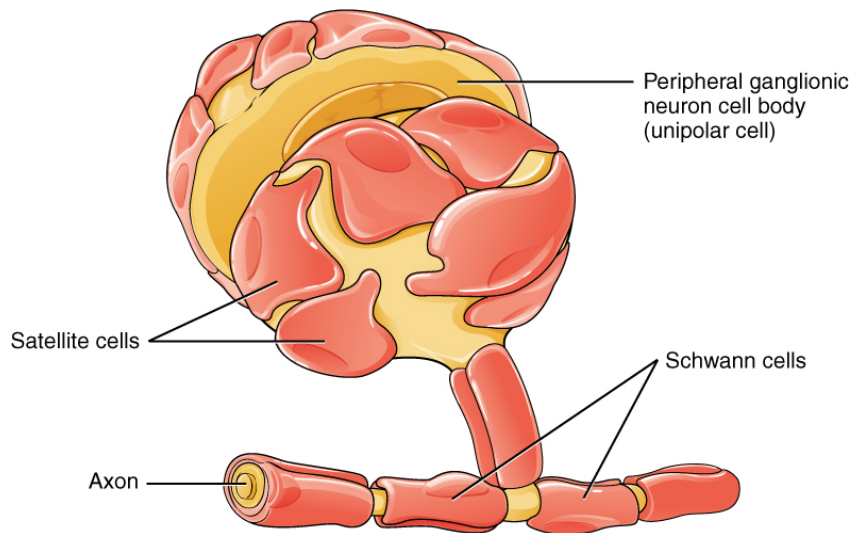
cerebrospinal fluid. Because of this, ependymal cells can be considered a component of the BBB, or a place where the BBB breaks down. These glial cells appear similar to epithelial cells, making a single layer of cells with little intracellular space and tight connections between adjacent cells. They also have cilia on their apical surface to help move the CSF through the ventricular space. The relationship of these glial cells to the structure of the CNS is seen in [\[link\]](#).

Glial Cells of the PNS

One of the two types of glial cells found in the PNS is the **satellite cell**. Satellite cells are found in sensory and autonomic ganglia, where they surround the cell bodies of neurons. This accounts for the name, based on their appearance under the microscope. They provide support, performing similar functions in the periphery as astrocytes do in the CNS—except, of course, for establishing the BBB.

The second type of glial cell is the **Schwann cell**, which insulate axons with myelin in the periphery. Schwann cells are different than oligodendrocytes, in that a Schwann cell wraps around a portion of only one axon segment and no others. Oligodendrocytes have processes that reach out to multiple axon segments, whereas the entire Schwann cell surrounds just one axon segment. The nucleus and cytoplasm of the Schwann cell are on the edge of the myelin sheath. The relationship of these two types of glial cells to ganglia and nerves in the PNS is seen in [\[link\]](#).

Glial Cells of the PNS



The PNS has satellite cells and Schwann cells.

Myelin

The insulation for axons in the nervous system is provided by glial cells, oligodendrocytes in the CNS, and Schwann cells in the PNS. Whereas the manner in which either cell is associated with the axon segment, or segments, that it insulates is different, the means of myelinating an axon segment is mostly the same in the two situations. Myelin is a lipid-rich sheath that surrounds the axon and by doing so creates a **myelin sheath** that facilitates the transmission of electrical signals along the axon. The lipids are essentially the phospholipids of the glial cell membrane. Myelin, however, is more than just the membrane of the glial cell. It also includes important proteins that are integral to that membrane. Some of the proteins help to hold the layers of the glial cell membrane closely together.

The appearance of the myelin sheath can be thought of as similar to the pastry wrapped around a hot dog for “pigs in a blanket” or a similar food. The glial cell is wrapped around the axon several times with little to no cytoplasm between the glial cell layers. For oligodendrocytes, the rest of the cell is separate from the myelin sheath as a cell process extends back

toward the cell body. A few other processes provide the same insulation for other axon segments in the area. For Schwann cells, the outermost layer of the cell membrane contains cytoplasm and the nucleus of the cell as a bulge on one side of the myelin sheath. During development, the glial cell is loosely or incompletely wrapped around the axon ([link](#)a). The edges of this loose enclosure extend toward each other, and one end tucks under the other. The inner edge wraps around the axon, creating several layers, and the other edge closes around the outside so that the axon is completely enclosed.

Note:

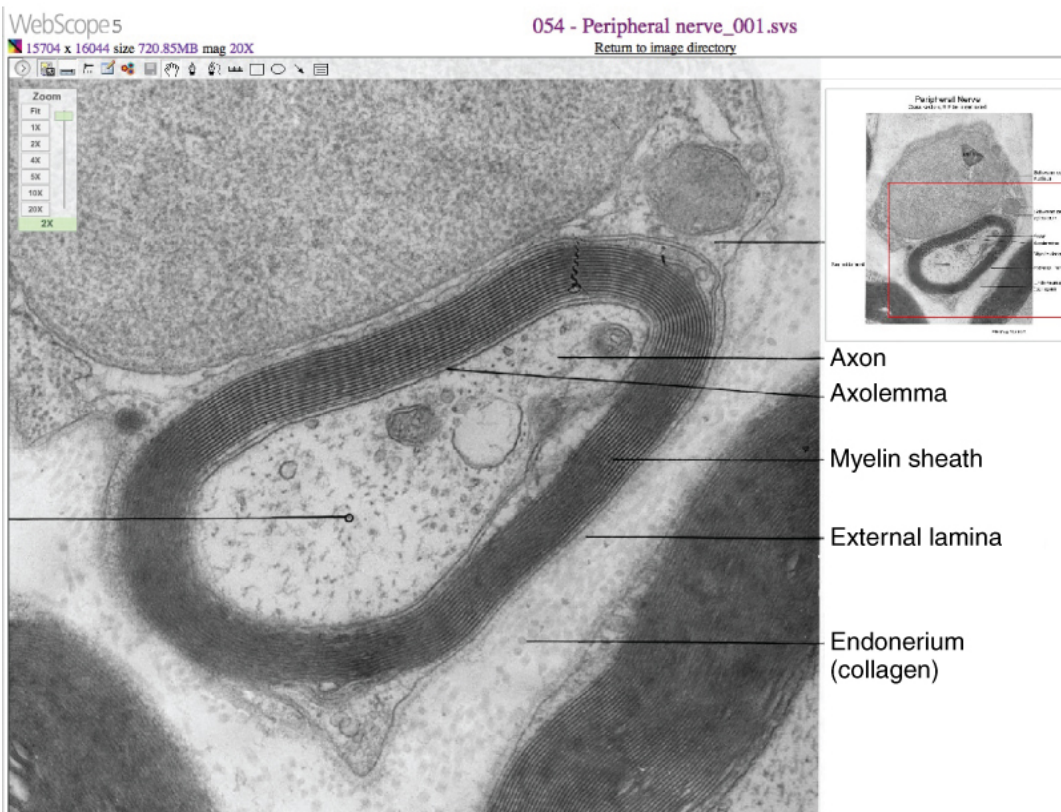
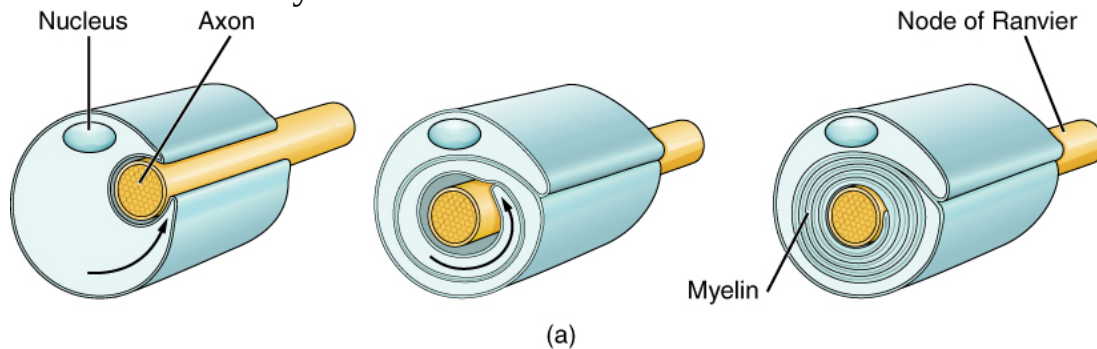


View the University of Michigan [WebScope](#) to see an electron micrograph of a cross-section of a myelinated nerve fiber. The axon contains microtubules and neurofilaments that are bounded by a plasma membrane known as the axolemma. Outside the plasma membrane of the axon is the myelin sheath, which is composed of the tightly wrapped plasma membrane of a Schwann cell. What aspects of the cells in this image react with the stain to make them a deep, dark, black color, such as the multiple layers that are the myelin sheath?

Myelin sheaths can extend for one or two millimeters, depending on the diameter of the axon. Axon diameters can be as small as 1 to 20 micrometers. Because a micrometer is 1/1000 of a millimeter, this means that the length of a myelin sheath can be 100–1000 times the diameter of the axon. [link](#), [link](#), and [link](#) show the myelin sheath surrounding an axon segment, but are not to scale. If the myelin sheath were drawn to scale,

the neuron would have to be immense—possibly covering an entire wall of the room in which you are sitting.

The Process of Myelination



Myelinating glia wrap several layers of cell membrane around the cell membrane of an axon segment. A single Schwann cell insulates a segment of a peripheral nerve, whereas in the CNS, an oligodendrocyte may provide insulation for a few separate axon segments. EM $\times 1,460,000$. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)

Note:

Disorders of the...

Nervous Tissue

Several diseases can result from the demyelination of axons. The causes of these diseases are not the same; some have genetic causes, some are caused by pathogens, and others are the result of autoimmune disorders. Though the causes are varied, the results are largely similar. The myelin insulation of axons is compromised, making electrical signaling slower.

Multiple sclerosis (MS) is one such disease. It is an example of an autoimmune disease. The antibodies produced by lymphocytes (a type of white blood cell) mark myelin as something that should not be in the body. This causes inflammation and the destruction of the myelin in the central nervous system. As the insulation around the axons is destroyed by the disease, scarring becomes obvious. This is where the name of the disease comes from; sclerosis means hardening of tissue, which is what a scar is. Multiple scars are found in the white matter of the brain and spinal cord. The symptoms of MS include both somatic and autonomic deficits. Control of the musculature is compromised, as is control of organs such as the bladder.

Guillain-Barré (pronounced gee-YAN bah-RAY) syndrome is an example of a demyelinating disease of the peripheral nervous system. It is also the result of an autoimmune reaction, but the inflammation is in peripheral nerves. Sensory symptoms or motor deficits are common, and autonomic failures can lead to changes in the heart rhythm or a drop in blood pressure, especially when standing, which causes dizziness.

Chapter Review

Nervous tissue contains two major cell types, neurons and glial cells. Neurons are the cells responsible for communication through electrical

signals. Glial cells are supporting cells, maintaining the environment around the neurons.

Neurons are polarized cells, based on the flow of electrical signals along their membrane. Signals are received at the dendrites, are passed along the cell body, and propagate along the axon towards the target, which may be another neuron, muscle tissue, or a gland. Many axons are insulated by a lipid-rich substance called myelin. Specific types of glial cells provide this insulation.

Several types of glial cells are found in the nervous system, and they can be categorized by the anatomical division in which they are found. In the CNS, astrocytes, oligodendrocytes, microglia, and ependymal cells are found. Astrocytes are important for maintaining the chemical environment around the neuron and are crucial for regulating the blood-brain barrier. Oligodendrocytes are the myelinating glia in the CNS. Microglia act as phagocytes and play a role in immune surveillance. Ependymal cells are responsible for filtering the blood to produce cerebrospinal fluid, which is a circulatory fluid that performs some of the functions of blood in the brain and spinal cord because of the BBB. In the PNS, satellite cells are supporting cells for the neurons, and Schwann cells insulate peripheral axons.

Interactive Link Questions

Exercise:

Problem:

Visit this [site](#) to learn about how nervous tissue is composed of neurons and glial cells. The neurons are dynamic cells with the ability to make a vast number of connections and to respond incredibly quickly to stimuli and to initiate movements based on those stimuli. They are the focus of intense research as failures in physiology can lead to devastating illnesses. Why are neurons only found in animals? Based on what this article says about neuron function, why wouldn't they be helpful for plants or microorganisms?

Solution:

Neurons enable thought, perception, and movement. Plants do not move, so they do not need this type of tissue. Microorganisms are too small to have a nervous system. Many are single-celled, and therefore have organelles for perception and movement.

Exercise:**Problem:**

View the University of Michigan [Webscope](#) to see an electron micrograph of a cross-section of a myelinated nerve fiber. The axon contains microtubules and neurofilaments, bounded by a plasma membrane known as the axolemma. Outside the plasma membrane of the axon is the myelin sheath, which is composed of the tightly wrapped plasma membrane of a Schwann cell. What aspects of the cells in this image react with the stain that makes them the deep, dark, black color, such as the multiple layers that are the myelin sheath?

Solution:

Lipid membranes, such as the cell membrane and organelle membranes.

Review Questions**Exercise:****Problem:**

What type of glial cell provides myelin for the axons in a tract?

- a. oligodendrocyte
 - b. astrocyte
 - c. Schwann cell
 - d. satellite cell
-

Solution:

A

Exercise:

Problem: Which part of a neuron contains the nucleus?

- a. dendrite
 - b. soma
 - c. axon
 - d. synaptic end bulb
-

Solution:

B

Exercise:

Problem:

Which of the following substances is least able to cross the blood-brain barrier?

- a. water
 - b. sodium ions
 - c. glucose
 - d. white blood cells
-

Solution:

D

Exercise:

Problem:

What type of glial cell is the resident macrophage behind the blood-brain barrier?

- a. microglia
- b. astrocyte
- c. Schwann cell
- d. satellite cell

Solution:

A

Exercise:**Problem:**

What two types of macromolecules are the main components of myelin?

- a. carbohydrates and lipids
- b. proteins and nucleic acids
- c. lipids and proteins
- d. carbohydrates and nucleic acids

Solution:

C

Critical Thinking Questions**Exercise:**

Problem:

Multiple sclerosis is a demyelinating disease affecting the central nervous system. What type of cell would be the most likely target of this disease? Why?

Solution:

The disease would target oligodendrocytes. In the CNS, oligodendrocytes provide the myelin for axons.

Exercise:**Problem:**

Which type of neuron, based on its shape, is best suited for relaying information directly from one neuron to another? Explain why.

Solution:

Bipolar cells, because they have one dendrite that receives input and one axon that provides output, would be a direct relay between two other cells.

Glossary**astrocyte**

glial cell type of the CNS that provides support for neurons and maintains the blood-brain barrier

axon hillock

tapering of the neuron cell body that gives rise to the axon

axon segment

single stretch of the axon insulated by myelin and bounded by nodes of Ranvier at either end (except for the first, which is after the initial segment, and the last, which is followed by the axon terminal)

axon terminal

end of the axon, where there are usually several branches extending toward the target cell

axoplasm

cytoplasm of an axon, which is different in composition than the cytoplasm of the neuronal cell body

bipolar

shape of a neuron with two processes extending from the neuron cell body—the axon and one dendrite

blood-brain barrier (BBB)

physiological barrier between the circulatory system and the central nervous system that establishes a privileged blood supply, restricting the flow of substances into the CNS

cerebrospinal fluid (CSF)

circulatory medium within the CNS that is produced by ependymal cells in the choroid plexus filtering the blood

choroid plexus

specialized structure containing ependymal cells that line blood capillaries and filter blood to produce CSF in the four ventricles of the brain

ependymal cell

glial cell type in the CNS responsible for producing cerebrospinal fluid

initial segment

first part of the axon as it emerges from the axon hillock, where the electrical signals known as action potentials are generated

microglia

glial cell type in the CNS that serves as the resident component of the immune system

multipolar

shape of a neuron that has multiple processes—the axon and two or more dendrites

myelin sheath

lipid-rich layer of insulation that surrounds an axon, formed by oligodendrocytes in the CNS and Schwann cells in the PNS; facilitates the transmission of electrical signals

node of Ranvier

gap between two myelinated regions of an axon, allowing for strengthening of the electrical signal as it propagates down the axon

oligodendrocyte

glial cell type in the CNS that provides the myelin insulation for axons in tracts

satellite cell

glial cell type in the PNS that provides support for neurons in the ganglia

Schwann cell

glial cell type in the PNS that provides the myelin insulation for axons in nerves

synapse

narrow junction across which a chemical signal passes from neuron to the next, initiating a new electrical signal in the target cell

synaptic end bulb

swelling at the end of an axon where neurotransmitter molecules are released onto a target cell across a synapse

unipolar

shape of a neuron which has only one process that includes both the axon and dendrite

ventricle

central cavity within the brain where CSF is produced and circulates

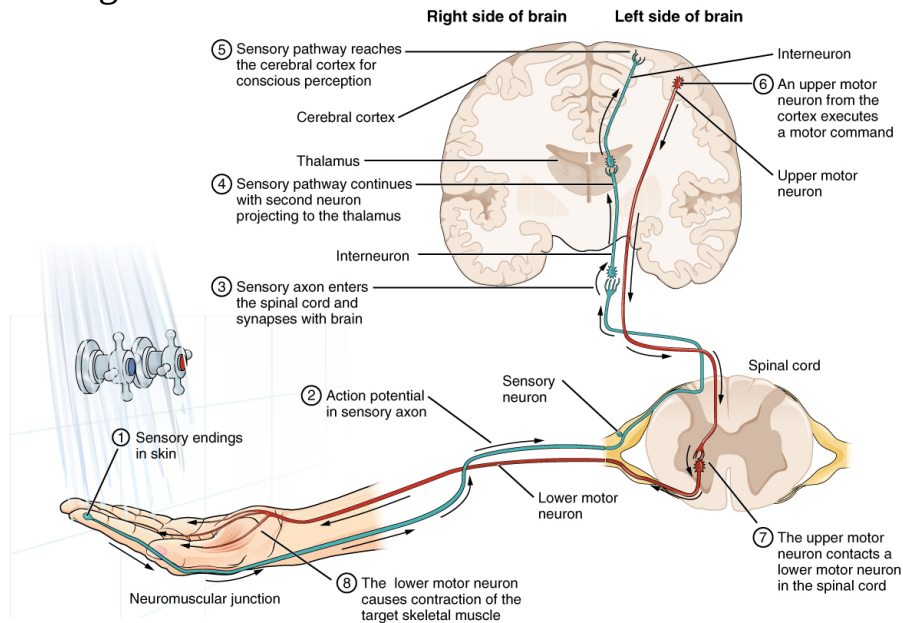
The Function of Nervous Tissue

By the end of this section, you will be able to:

- Distinguish the major functions of the nervous system: sensation, integration, and response
- List the sequence of events in a simple sensory receptor–motor response pathway

Having looked at the components of nervous tissue, and the basic anatomy of the nervous system, next comes an understanding of how nervous tissue is capable of communicating within the nervous system. Before getting to the nuts and bolts of how this works, an illustration of how the components come together will be helpful. An example is summarized in [\[link\]](#).

Testing the Water



- (1) The sensory neuron has endings in the skin that sense a stimulus such as water temperature. The strength of the signal that starts here is dependent on the strength of the stimulus.
- (2) The graded potential from the sensory endings, if strong enough, will initiate an action potential at the initial segment of the axon (which is immediately adjacent to the sensory endings in the skin).
- (3)

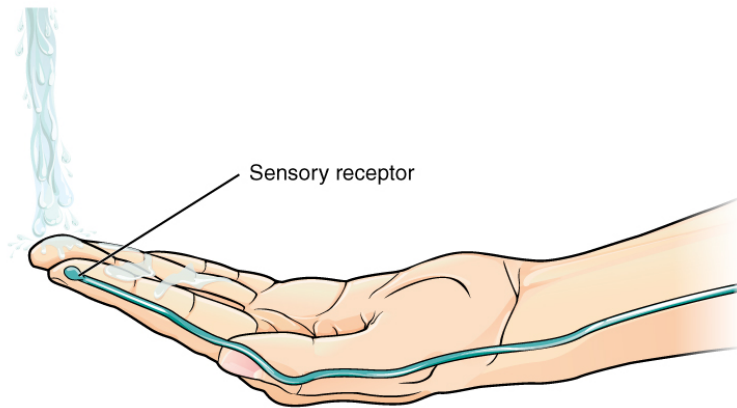
The axon of the peripheral sensory neuron enters the spinal cord and contacts another neuron in the gray matter. The contact is a synapse where another graded potential is caused by the release of a chemical signal from the axon terminals. (4) An action potential is initiated at the initial segment of this neuron and travels up the sensory pathway to a region of the brain called the thalamus. Another synapse passes the information along to the next neuron. (5) The sensory pathway ends when the signal reaches the cerebral cortex. (6) After integration with neurons in other parts of the cerebral cortex, a motor command is sent from the precentral gyrus of the frontal cortex. (7) The upper motor neuron sends an action potential down to the spinal cord. The target of the upper motor neuron is the dendrites of the lower motor neuron in the gray matter of the spinal cord. (8) The axon of the lower motor neuron emerges from the spinal cord in a nerve and connects to a muscle through a neuromuscular junction to cause contraction of the target muscle.

Imagine you are about to take a shower in the morning before going to school. You have turned on the faucet to start the water as you prepare to get in the shower. After a few minutes, you expect the water to be a temperature that will be comfortable to enter. So you put your hand out into the spray of water. What happens next depends on how your nervous system interacts with the stimulus of the water temperature and what you do in response to that stimulus.

Found in the skin of your fingers or toes is a type of sensory receptor that is sensitive to temperature, called a **thermoreceptor**. When you place your hand under the shower ([\[link\]](#)), the cell membrane of the thermoreceptors changes its electrical state (voltage). The amount of change is dependent on

the strength of the stimulus (how hot the water is). This is called a **graded potential**. If the stimulus is strong, the voltage of the cell membrane will change enough to generate an electrical signal that will travel down the axon. You have learned about this type of signaling before, with respect to the interaction of nerves and muscles at the neuromuscular junction. The voltage at which such a signal is generated is called the **threshold**, and the resulting electrical signal is called an **action potential**. In this example, the action potential travels—a process known as **propagation**—along the axon from the axon hillock to the axon terminals and into the synaptic end bulbs. When this signal reaches the end bulbs, it causes the release of a signaling molecule called a **neurotransmitter**.

The Sensory Input



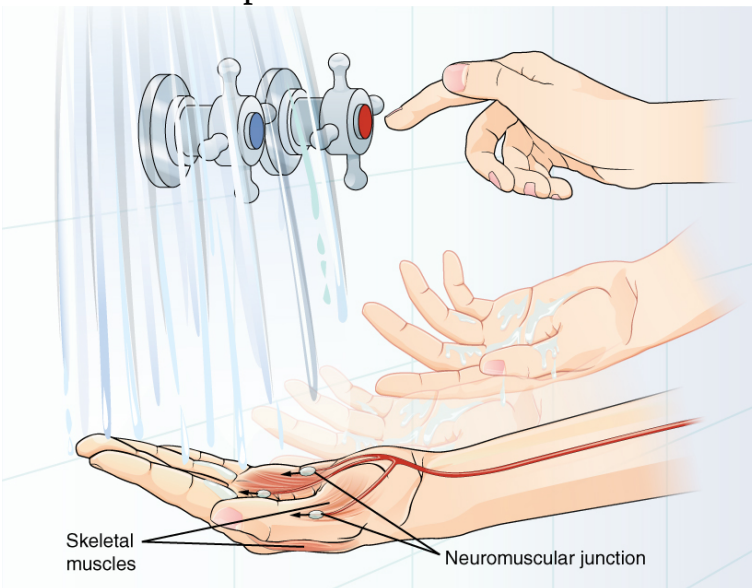
Receptors in the skin sense the temperature of the water.

The neurotransmitter diffuses across the short distance of the synapse and binds to a receptor protein of the target neuron. When the molecular signal binds to the receptor, the cell membrane of the target neuron changes its electrical state and a new graded potential begins. If that graded potential is strong enough to reach threshold, the second neuron generates an action potential at its axon hillock. The target of this neuron is another neuron in the **thalamus** of the brain, the part of the CNS that acts as a relay for sensory information. At another synapse, neurotransmitter is released and binds to its receptor. The thalamus then sends the sensory information to the

cerebral cortex, the outermost layer of gray matter in the brain, where conscious perception of that water temperature begins.

Within the cerebral cortex, information is processed among many neurons, integrating the stimulus of the water temperature with other sensory stimuli, with your emotional state (you just aren't ready to wake up; the bed is calling to you), memories (perhaps of the lab notes you have to study before a quiz). Finally, a plan is developed about what to do, whether that is to turn the temperature up, turn the whole shower off and go back to bed, or step into the shower. To do any of these things, the cerebral cortex has to send a command out to your body to move muscles ([link](#)).

The Motor Response



On the basis of the sensory input and the integration in the CNS, a motor response is formulated and executed.

A region of the cortex is specialized for sending signals down to the spinal cord for movement. The **upper motor neuron** is in this region, called the **precentral gyrus of the frontal cortex**, which has an axon that extends all the way down the spinal cord. At the level of the spinal cord at which this axon makes a synapse, a graded potential occurs in the cell membrane of a

lower motor neuron. This second motor neuron is responsible for causing muscle fibers to contract. In the manner described in the chapter on muscle tissue, an action potential travels along the motor neuron axon into the periphery. The axon terminates on muscle fibers at the neuromuscular junction. Acetylcholine is released at this specialized synapse, which causes the muscle action potential to begin, following a large potential known as an end plate potential. When the lower motor neuron excites the muscle fiber, it contracts. All of this occurs in a fraction of a second, but this story is the basis of how the nervous system functions.

Note:

Career Connections

Neurophysiologist

Understanding how the nervous system works could be a driving force in your career. Studying neurophysiology is a very rewarding path to follow. It means that there is a lot of work to do, but the rewards are worth the effort.

The career path of a research scientist can be straightforward: college, graduate school, postdoctoral research, academic research position at a university. A Bachelor's degree in science will get you started, and for neurophysiology that might be in biology, psychology, computer science, engineering, or neuroscience. But the real specialization comes in graduate school. There are many different programs out there to study the nervous system, not just neuroscience itself. Most graduate programs are doctoral, meaning that a Master's degree is not part of the work. These are usually considered five-year programs, with the first two years dedicated to course work and finding a research mentor, and the last three years dedicated to finding a research topic and pursuing that with a near single-mindedness. The research will usually result in a few publications in scientific journals, which will make up the bulk of a doctoral dissertation. After graduating with a Ph.D., researchers will go on to find specialized work called a postdoctoral fellowship within established labs. In this position, a researcher starts to establish their own research career with the hopes of finding an academic position at a research university.

Other options are available if you are interested in how the nervous system works. Especially for neurophysiology, a medical degree might be more suitable so you can learn about the clinical applications of neurophysiology and possibly work with human subjects. An academic career is not a necessity. Biotechnology firms are eager to find motivated scientists ready to tackle the tough questions about how the nervous system works so that therapeutic chemicals can be tested on some of the most challenging disorders such as Alzheimer's disease or Parkinson's disease, or spinal cord injury.

Others with a medical degree and a specialization in neuroscience go on to work directly with patients, diagnosing and treating mental disorders. You can do this as a psychiatrist, a neuropsychologist, a neuroscience nurse, or a neurodiagnostic technician, among other possible career paths.

Chapter Review

Sensation starts with the activation of a sensory ending, such as the thermoreceptor in the skin sensing the temperature of the water. The sensory endings in the skin initiate an electrical signal that travels along the sensory axon within a nerve into the spinal cord, where it synapses with a neuron in the gray matter of the spinal cord. The temperature information represented in that electrical signal is passed to the next neuron by a chemical signal that diffuses across the small gap of the synapse and initiates a new electrical signal in the target cell. That signal travels through the sensory pathway to the brain, passing through the thalamus, where conscious perception of the water temperature is made possible by the cerebral cortex. Following integration of that information with other cognitive processes and sensory information, the brain sends a command back down to the spinal cord to initiate a motor response by controlling a skeletal muscle. The motor pathway is composed of two cells, the upper motor neuron and the lower motor neuron. The upper motor neuron has its cell body in the cerebral cortex and synapses on a cell in the gray matter of the spinal cord. The lower motor neuron is that cell in the gray matter of the spinal cord and its axon extends into the periphery where it synapses with a skeletal muscle in a neuromuscular junction.

Review Questions

Exercise:

Problem:

If a thermoreceptor is sensitive to temperature sensations, what would a chemoreceptor be sensitive to?

- a. light
- b. sound
- c. molecules
- d. vibration

Solution:

C

Exercise:

Problem:

Which of these locations is where the greatest level of integration is taking place in the example of testing the temperature of the shower?

- a. skeletal muscle
- b. spinal cord
- c. thalamus
- d. cerebral cortex

Solution:

D

Exercise:

Problem:

How long does all the signaling through the sensory pathway, within the central nervous system, and through the motor command pathway take?

- a. 1 to 2 minutes
- b. 1 to 2 seconds
- c. fraction of a second
- d. varies with graded potential

Solution:

C

Exercise:

Problem:What is the target of an upper motor neuron?

- a. cerebral cortex
- b. lower motor neuron
- c. skeletal muscle
- d. thalamus

Solution:

B

Critical Thinking Questions**Exercise:**

Problem:

Sensory fibers, or pathways, are referred to as “afferent.” Motor fibers, or pathways, are referred to as “efferent.” What can you infer about the meaning of these two terms (afferent and efferent) in a structural or anatomical context?

Solution:

Afferent means “toward,” as in sensory information traveling from the periphery into the CNS. Efferent means “away from,” as in motor commands that travel from the brain down the spinal cord and out into the periphery.

Exercise:**Problem:**

If a person has a motor disorder and cannot move their arm voluntarily, but their muscles have tone, which motor neuron—upper or lower—is probably affected? Explain why.

Solution:

The upper motor neuron would be affected because it is carrying the command from the brain down.

Glossary**action potential**

change in voltage of a cell membrane in response to a stimulus that results in transmission of an electrical signal; unique to neurons and muscle fibers

cerebral cortex

outermost layer of gray matter in the brain, where conscious perception takes place

graded potential

change in the membrane potential that varies in size, depending on the size of the stimulus that elicits it

lower motor neuron

second neuron in the motor command pathway that is directly connected to the skeletal muscle

neurotransmitter

chemical signal that is released from the synaptic end bulb of a neuron to cause a change in the target cell

precentral gyrus of the frontal cortex

region of the cerebral cortex responsible for generating motor commands, where the upper motor neuron cell body is located

propagation

movement of an action potential along the length of an axon

thalamus

region of the central nervous system that acts as a relay for sensory pathways

thermoreceptor

type of sensory receptor capable of transducing temperature stimuli into neural action potentials

threshold

membrane voltage at which an action potential is initiated

upper motor neuron

first neuron in the motor command pathway with its cell body in the cerebral cortex that synapses on the lower motor neuron in the spinal cord

The Action Potential

By the end of this section, you will be able to:

- Describe the components of the membrane that establish the resting membrane potential
- Describe the changes that occur to the membrane that result in the action potential

The functions of the nervous system—sensation, integration, and response—depend on the functions of the neurons underlying these pathways. To understand how neurons are able to communicate, it is necessary to describe the role of an **excitable membrane** in generating these signals. The basis of this communication is the action potential, which demonstrates how changes in the membrane can constitute a signal. Looking at the way these signals work in more variable circumstances involves a look at graded potentials, which will be covered in the next section.

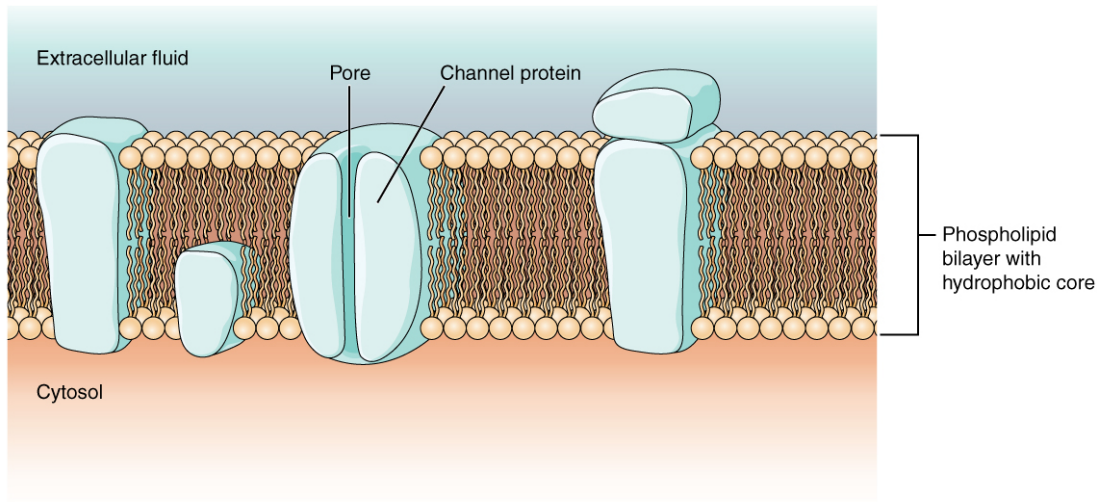
Electrically Active Cell Membranes

Most cells in the body make use of charged particles, ions, to build up a charge across the cell membrane. Previously, this was shown to be a part of how muscle cells work. For skeletal muscles to contract, based on excitation–contraction coupling, requires input from a neuron. Both of the cells make use of the cell membrane to regulate ion movement between the extracellular fluid and cytosol.

As you learned in the chapter on cells, the cell membrane is primarily responsible for regulating what can cross the membrane and what stays on only one side. The cell membrane is a phospholipid bilayer, so only substances that can pass directly through the hydrophobic core can diffuse through unaided. Charged particles, which are hydrophilic by definition, cannot pass through the cell membrane without assistance ([\[link\]](#)). Transmembrane proteins, specifically channel proteins, make this possible. Several passive transport channels, as well as active transport pumps, are necessary to generate a transmembrane potential and an action potential. Of special interest is the carrier protein referred to as the sodium/potassium pump that moves sodium ions (Na^+) out of a cell and potassium ions (K^+)

into a cell, thus regulating ion concentration on both sides of the cell membrane.

Cell Membrane and Transmembrane Proteins



The cell membrane is composed of a phospholipid bilayer and has many transmembrane proteins, including different types of channel proteins that serve as ion channels.

The sodium/potassium pump requires energy in the form of adenosine triphosphate (ATP), so it is also referred to as an ATPase. As was explained in the cell chapter, the concentration of Na^+ is higher outside the cell than inside, and the concentration of K^+ is higher inside the cell than outside. That means that this pump is moving the ions against the concentration gradients for sodium and potassium, which is why it requires energy. In fact, the pump basically maintains those concentration gradients.

Ion channels are pores that allow specific charged particles to cross the membrane in response to an existing concentration gradient. Proteins are capable of spanning the cell membrane, including its hydrophobic core, and can interact with the charge of ions because of the varied properties of amino acids found within specific domains or regions of the protein channel. Hydrophobic amino acids are found in the domains that are apposed to the hydrocarbon tails of the phospholipids. Hydrophilic amino acids are exposed to the fluid environments of the extracellular fluid and

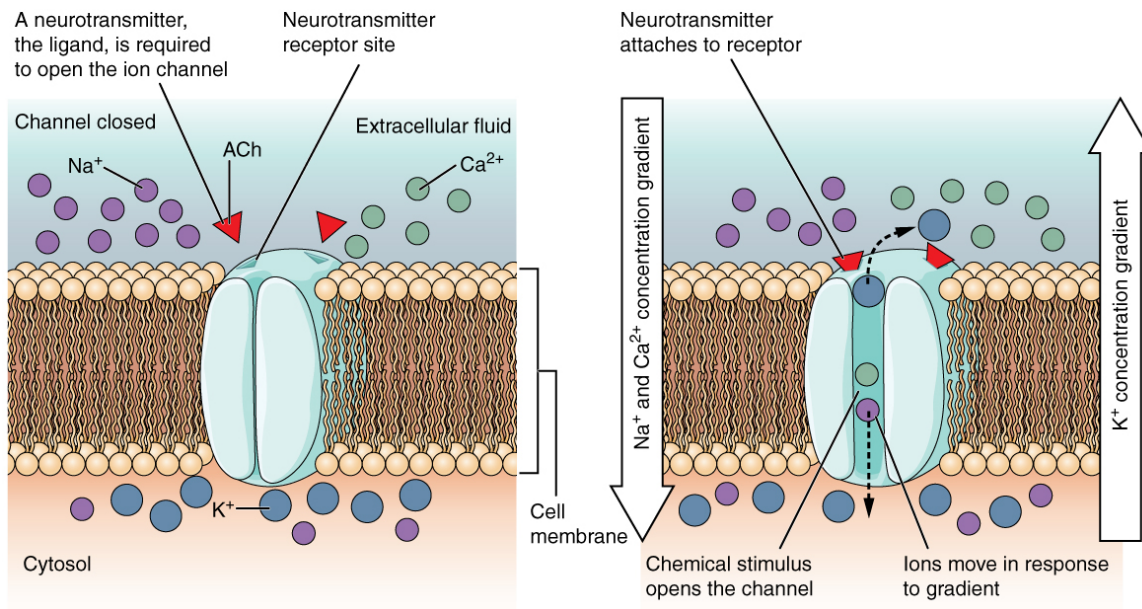
cytosol. Additionally, the ions will interact with the hydrophilic amino acids, which will be selective for the charge of the ion. Channels for cations (positive ions) will have negatively charged side chains in the pore. Channels for anions (negative ions) will have positively charged side chains in the pore. This is called **electrochemical exclusion**, meaning that the channel pore is charge-specific.

Ion channels can also be specified by the diameter of the pore. The distance between the amino acids will be specific for the diameter of the ion when it dissociates from the water molecules surrounding it. Because of the surrounding water molecules, larger pores are not ideal for smaller ions because the water molecules will interact, by hydrogen bonds, more readily than the amino acid side chains. This is called **size exclusion**. Some ion channels are selective for charge but not necessarily for size, and thus are called a **nonspecific channel**. These nonspecific channels allow cations—particularly Na^+ , K^+ , and Ca^{2+} —to cross the membrane, but exclude anions.

Ion channels do not always freely allow ions to diffuse across the membrane. Some are opened by certain events, meaning the channels are **gated**. So another way that channels can be categorized is on the basis of how they are gated. Although these classes of ion channels are found primarily in the cells of nervous or muscular tissue, they also can be found in the cells of epithelial and connective tissues.

A **ligand-gated channel** opens because a signaling molecule, a ligand, binds to the extracellular region of the channel. This type of channel is also known as an **ionotropic receptor** because when the ligand, known as a neurotransmitter in the nervous system, binds to the protein, ions cross the membrane changing its charge ([link](#)).

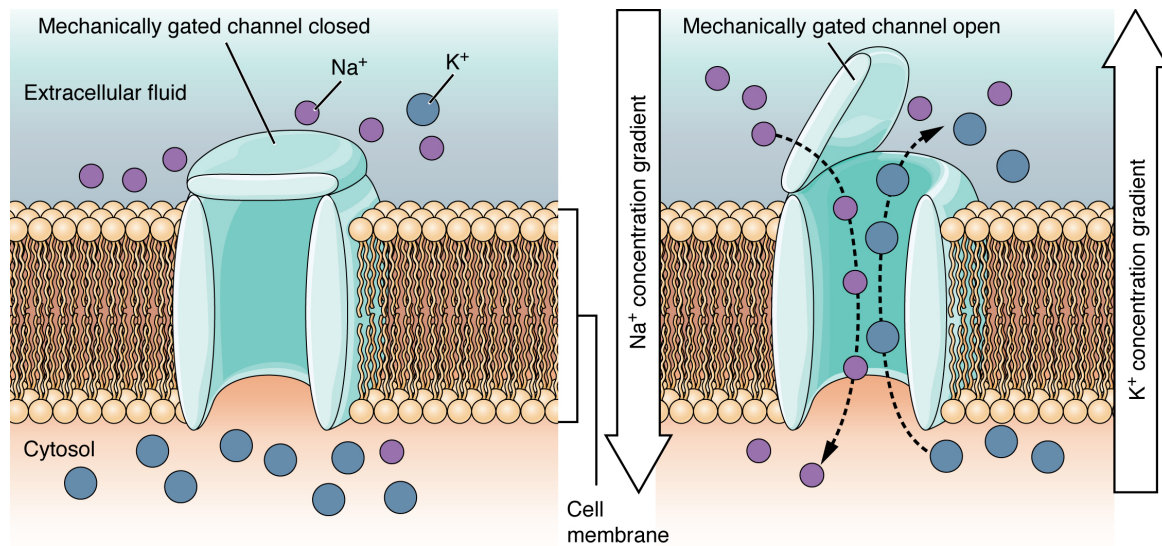
Ligand-Gated Channels



When the ligand, in this case the neurotransmitter acetylcholine, binds to a specific location on the extracellular surface of the channel protein, the pore opens to allow select ions through. The ions, in this case, are cations of sodium, calcium, and potassium.

A **mechanically gated channel** opens because of a physical distortion of the cell membrane. Many channels associated with the sense of touch (somatosensation) are mechanically gated. For example, as pressure is applied to the skin, these channels open and allow ions to enter the cell. Similar to this type of channel would be the channel that opens on the basis of temperature changes, as in testing the water in the shower ([link](#)).

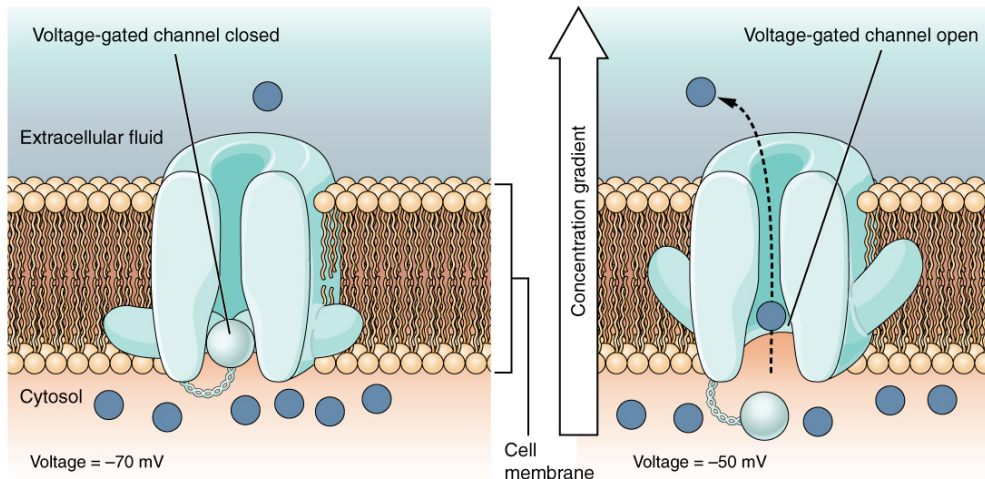
Mechanically Gated Channels



When a mechanical change occurs in the surrounding tissue, such as pressure or touch, the channel is physically opened. Thermoreceptors work on a similar principle. When the local tissue temperature changes, the protein reacts by physically opening the channel.

A **voltage-gated channel** is a channel that responds to changes in the electrical properties of the membrane in which it is embedded. Normally, the inner portion of the membrane is at a negative voltage. When that voltage becomes less negative, the channel begins to allow ions to cross the membrane ([link](#)).

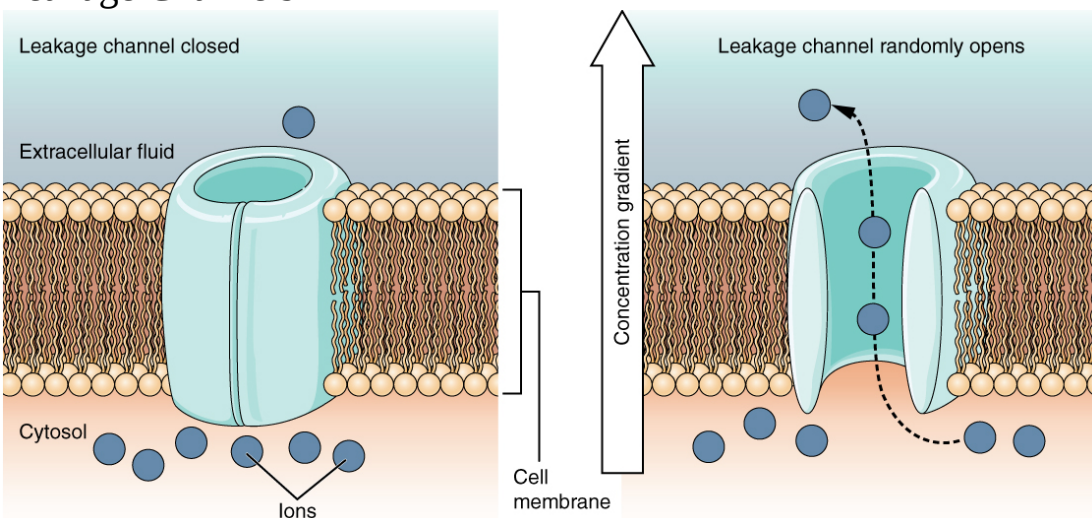
Voltage-Gated Channels



Voltage-gated channels open when the transmembrane voltage changes around them. Amino acids in the structure of the protein are sensitive to charge and cause the pore to open to the selected ion.

A **leakage channel** is randomly gated, meaning that it opens and closes at random, hence the reference to leaking. There is no actual event that opens the channel; instead, it has an intrinsic rate of switching between the open and closed states. Leakage channels contribute to the resting transmembrane voltage of the excitable membrane ([\[link\]](#)).

Leakage Channels

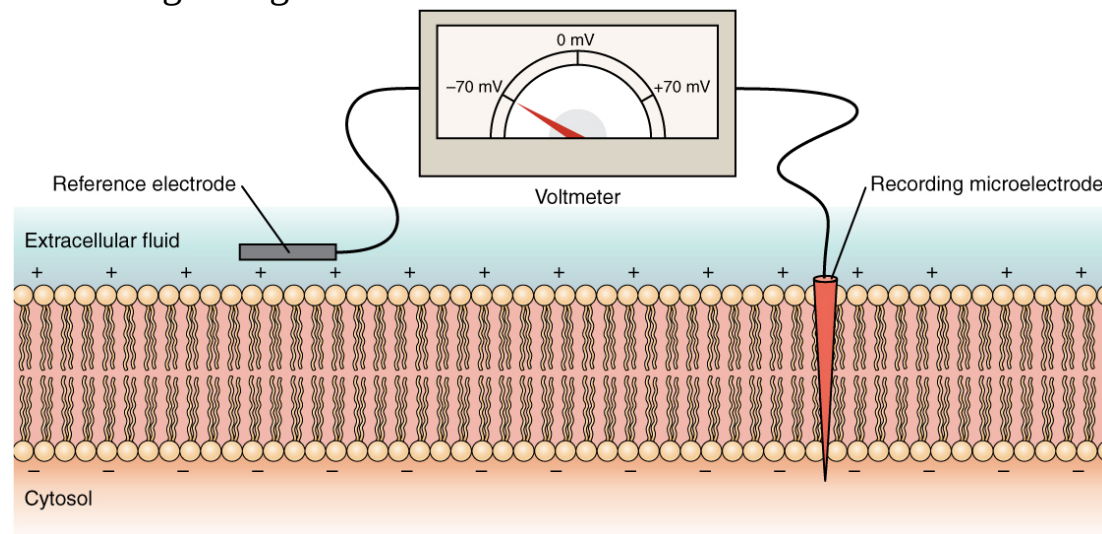


In certain situations, ions need to move across the membrane randomly. The particular electrical properties of certain cells are modified by the presence of this type of channel.

The Membrane Potential

The electrical state of the cell membrane can have several variations. These are all variations in the **membrane potential**. A potential is a distribution of charge across the cell membrane, measured in millivolts (mV). The standard is to compare the inside of the cell relative to the outside, so the membrane potential is a value representing the charge on the intracellular side of the membrane based on the outside being zero, relatively speaking ([link](#)).

Measuring Charge across a Membrane with a Voltmeter



A recording electrode is inserted into the cell and a reference electrode is outside the cell. By comparing the charge measured by these two electrodes, the transmembrane voltage is determined. It is conventional to express that value for the cytosol relative to the outside.

The concentration of ions in extracellular and intracellular fluids is largely balanced, with a net neutral charge. However, a slight difference in charge occurs right at the membrane surface, both internally and externally. It is the difference in this very limited region that has all the power in neurons (and muscle cells) to generate electrical signals, including action potentials.

Before these electrical signals can be described, the resting state of the membrane must be explained. When the cell is at rest, and the ion channels are closed (except for leakage channels which randomly open), ions are distributed across the membrane in a very predictable way. The concentration of Na^+ outside the cell is 10 times greater than the concentration inside. Also, the concentration of K^+ inside the cell is greater than outside. The cytosol contains a high concentration of anions, in the form of phosphate ions and negatively charged proteins. Large anions are a component of the inner cell membrane, including specialized phospholipids and proteins associated with the inner leaflet of the membrane (leaflet is a term used for one side of the lipid bilayer membrane). The negative charge is localized in the large anions.

With the ions distributed across the membrane at these concentrations, the difference in charge is measured at -70 mV, the value described as the **resting membrane potential**. The exact value measured for the resting membrane potential varies between cells, but -70 mV is most commonly used as this value. This voltage would actually be much lower except for the contributions of some important proteins in the membrane. Leakage channels allow Na^+ to slowly move into the cell or K^+ to slowly move out, and the Na^+/K^+ pump restores them. This may appear to be a waste of energy, but each has a role in maintaining the membrane potential.

The Action Potential

Resting membrane potential describes the steady state of the cell, which is a dynamic process that is balanced by ion leakage and ion pumping. Without any outside influence, it will not change. To get an electrical signal started, the membrane potential has to change.

This starts with a channel opening for Na^+ in the membrane. Because the concentration of Na^+ is higher outside the cell than inside the cell by a factor of 10, ions will rush into the cell that are driven largely by the concentration gradient. Because sodium is a positively charged ion, it will change the relative voltage immediately inside the cell relative to immediately outside. The resting potential is the state of the membrane at a voltage of -70 mV, so the sodium cation entering the cell will cause it to become less negative. This is known as **depolarization**, meaning the membrane potential moves toward zero.

The concentration gradient for Na^+ is so strong that it will continue to enter the cell even after the membrane potential has become zero, so that the voltage immediately around the pore begins to become positive. The electrical gradient also plays a role, as negative proteins below the membrane attract the sodium ion. The membrane potential will reach +30 mV by the time sodium has entered the cell.

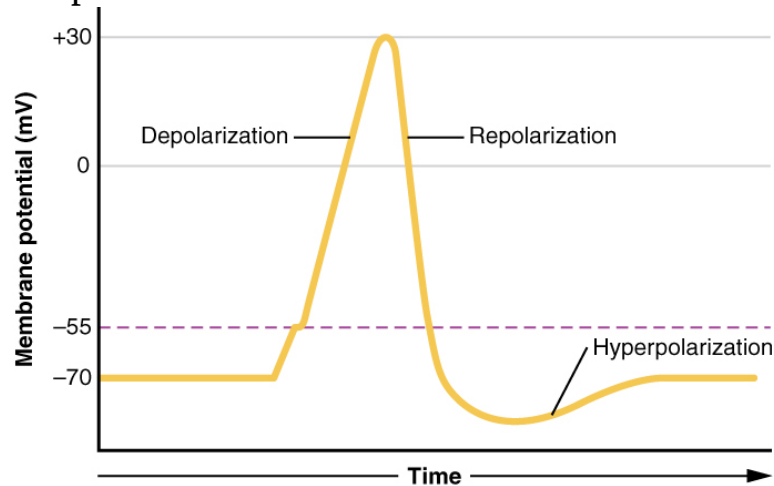
As the membrane potential reaches +30 mV, other voltage-gated channels are opening in the membrane. These channels are specific for the potassium ion. A concentration gradient acts on K^+ , as well. As K^+ starts to leave the cell, taking a positive charge with it, the membrane potential begins to move back toward its resting voltage. This is called **repolarization**, meaning that the membrane voltage moves back toward the -70 mV value of the resting membrane potential.

Repolarization returns the membrane potential to the -70 mV value that indicates the resting potential, but it actually overshoots that value. Potassium ions reach equilibrium when the membrane voltage is below -70 mV, so a period of hyperpolarization occurs while the K^+ channels are open. Those K^+ channels are slightly delayed in closing, accounting for this short overshoot.

What has been described here is the action potential, which is presented as a graph of voltage over time in [\[link\]](#). It is the electrical signal that nervous tissue generates for communication. The change in the membrane voltage from -70 mV at rest to +30 mV at the end of depolarization is a 100-mV change. That can also be written as a 0.1-V change. To put that value in perspective, think about a battery. An AA battery that you might find in a

television remote has a voltage of 1.5 V, or a 9-V battery (the rectangular battery with two posts on one end) is, obviously, 9 V. The change seen in the action potential is one or two orders of magnitude less than the charge in these batteries. In fact, the membrane potential can be described as a battery. A charge is stored across the membrane that can be released under the correct conditions. A battery in your remote has stored a charge that is “released” when you push a button.

Graph of Action Potential



Plotting voltage measured across the cell membrane against time, the action potential begins with depolarization, followed by repolarization, which goes past the resting potential into hyperpolarization, and finally the membrane returns to rest.

Note:



What happens across the membrane of an electrically active cell is a dynamic process that is hard to visualize with static images or through text descriptions. View this [animation](#) to learn more about this process. What is the difference between the driving force for Na^+ and K^+ ? And what is similar about the movement of these two ions?

The question is, now, what initiates the action potential? The description above conveniently glosses over that point. But it is vital to understanding what is happening. The membrane potential will stay at the resting voltage until something changes. The description above just says that a Na^+ channel opens. Now, to say “a channel opens” does not mean that one individual transmembrane protein changes. Instead, it means that one kind of channel opens. There are a few different types of channels that allow Na^+ to cross the membrane. A ligand-gated Na^+ channel will open when a neurotransmitter binds to it and a mechanically gated Na^+ channel will open when a physical stimulus affects a sensory receptor (like pressure applied to the skin compresses a touch receptor). Whether it is a neurotransmitter binding to its receptor protein or a sensory stimulus activating a sensory receptor cell, some stimulus gets the process started. Sodium starts to enter the cell and the membrane becomes less negative.

A third type of channel that is an important part of depolarization in the action potential is the voltage-gated Na^+ channel. The channels that start depolarizing the membrane because of a stimulus help the cell to depolarize from -70 mV to -55 mV . Once the membrane reaches that voltage, the voltage-gated Na^+ channels open. This is what is known as the threshold. Any depolarization that does not change the membrane potential to -55 mV or higher will not reach threshold and thus will not result in an action potential. Also, any stimulus that depolarizes the membrane to -55 mV or

beyond will cause a large number of channels to open and an action potential will be initiated.

Because of the threshold, the action potential can be likened to a digital event—it either happens or it does not. If the threshold is not reached, then no action potential occurs. If depolarization reaches -55 mV , then the action potential continues and runs all the way to $+30\text{ mV}$, at which K^+ causes repolarization, including the hyperpolarizing overshoot. Also, those changes are the same for every action potential, which means that once the threshold is reached, the exact same thing happens. A stronger stimulus, which might depolarize the membrane well past threshold, will not make a “bigger” action potential. Action potentials are “all or none.” Either the membrane reaches the threshold and everything occurs as described above, or the membrane does not reach the threshold and nothing else happens. All action potentials peak at the same voltage ($+30\text{ mV}$), so one action potential is not bigger than another. Stronger stimuli will initiate multiple action potentials more quickly, but the individual signals are not bigger. Thus, for example, you will not feel a greater sensation of pain, or have a stronger muscle contraction, because of the size of the action potential because they are not different sizes.

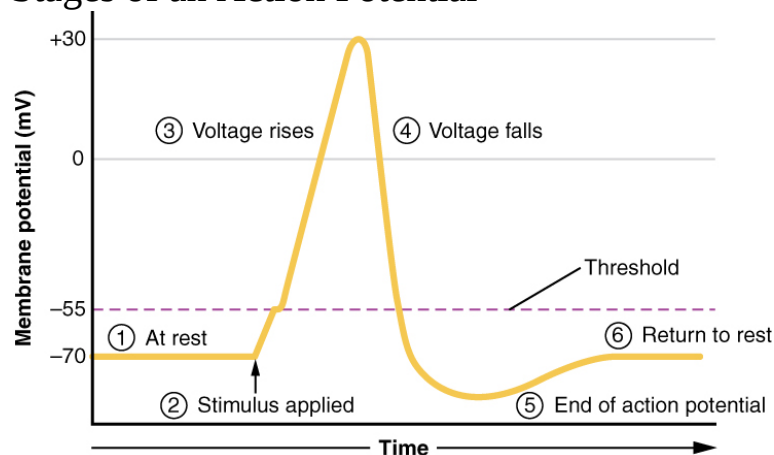
As we have seen, the depolarization and repolarization of an action potential are dependent on two types of channels (the voltage-gated Na^+ channel and the voltage-gated K^+ channel). The voltage-gated Na^+ channel actually has two gates. One is the **activation gate**, which opens when the membrane potential crosses -55 mV . The other gate is the **inactivation gate**, which closes after a specific period of time—on the order of a fraction of a millisecond. When a cell is at rest, the activation gate is closed and the inactivation gate is open. However, when the threshold is reached, the activation gate opens, allowing Na^+ to rush into the cell. Timed with the peak of depolarization, the inactivation gate closes. During repolarization, no more sodium can enter the cell. When the membrane potential passes -55 mV again, the activation gate closes. After that, the inactivation gate re-opens, making the channel ready to start the whole process over again.

The voltage-gated K^+ channel has only one gate, which is sensitive to a membrane voltage of -50 mV . However, it does not open as quickly as the

voltage-gated Na^+ channel does. It might take a fraction of a millisecond for the channel to open once that voltage has been reached. The timing of this coincides exactly with when the Na^+ flow peaks, so voltage-gated K^+ channels open just as the voltage-gated Na^+ channels are being inactivated. As the membrane potential repolarizes and the voltage passes -50 mV again, the channel closes—again, with a little delay. Potassium continues to leave the cell for a short while and the membrane potential becomes more negative, resulting in the hyperpolarizing overshoot. Then the channel closes again and the membrane can return to the resting potential because of the ongoing activity of the non-gated channels and the Na^+/K^+ pump.

All of this takes place within approximately 2 milliseconds ([\[link\]](#)). While an action potential is in progress, another one cannot be initiated. That effect is referred to as the **refractory period**. There are two phases of the refractory period: the **absolute refractory period** and the **relative refractory period**. During the absolute phase, another action potential will not start. This is because of the inactivation gate of the voltage-gated Na^+ channel. Once that channel is back to its resting conformation (less than -55 mV), a new action potential could be started, but only by a stronger stimulus than the one that initiated the current action potential. This is because of the flow of K^+ out of the cell. Because that ion is rushing out, any Na^+ that tries to enter will not depolarize the cell, but will only keep the cell from hyperpolarizing.

Stages of an Action Potential



Plotting voltage measured across the cell membrane against time, the events of the

action potential can be related to specific changes in the membrane voltage. (1) At rest, the membrane voltage is -70 mV. (2) The membrane begins to depolarize when an external stimulus is applied. (3) The membrane voltage begins a rapid rise toward +30 mV. (4) The membrane voltage starts to return to a negative value. (5) Repolarization continues past the resting membrane voltage, resulting in hyperpolarization. (6) The membrane voltage returns to the resting value shortly after hyperpolarization.

Propagation of the Action Potential

The action potential is initiated at the beginning of the axon, at what is called the initial segment. There is a high density of voltage-gated Na^+ channels so that rapid depolarization can take place here. Going down the length of the axon, the action potential is propagated because more voltage-gated Na^+ channels are opened as the depolarization spreads. This spreading occurs because Na^+ enters through the channel and moves along the inside of the cell membrane. As the Na^+ moves, or flows, a short distance along the cell membrane, its positive charge depolarizes a little more of the cell membrane. As that depolarization spreads, new voltage-gated Na^+ channels open and more ions rush into the cell, spreading the depolarization a little farther.

Because voltage-gated Na^+ channels are inactivated at the peak of the depolarization, they cannot be opened again for a brief time—the absolute refractory period. Because of this, depolarization spreading back toward previously opened channels has no effect. The action potential must propagate toward the axon terminals; as a result, the polarity of the neuron is maintained, as mentioned above.

Propagation, as described above, applies to unmyelinated axons. When myelination is present, the action potential propagates differently. Sodium ions that enter the cell at the initial segment start to spread along the length of the axon segment, but there are no voltage-gated Na^+ channels until the first node of Ranvier. Because there is not constant opening of these channels along the axon segment, the depolarization spreads at an optimal speed. The distance between nodes is the optimal distance to keep the membrane still depolarized above threshold at the next node. As Na^+ spreads along the inside of the membrane of the axon segment, the charge starts to dissipate. If the node were any farther down the axon, that depolarization would have fallen off too much for voltage-gated Na^+ channels to be activated at the next node of Ranvier. If the nodes were any closer together, the speed of propagation would be slower.

Propagation along an unmyelinated axon is referred to as **continuous conduction**; along the length of a myelinated axon, it is **saltatory conduction**. Continuous conduction is slow because there are always voltage-gated Na^+ channels opening, and more and more Na^+ is rushing into the cell. Saltatory conduction is faster because the action potential basically jumps from one node to the next (saltare = “to leap”), and the new influx of Na^+ renews the depolarized membrane. Along with the myelination of the axon, the diameter of the axon can influence the speed of conduction. Much as water runs faster in a wide river than in a narrow creek, Na^+ -based depolarization spreads faster down a wide axon than down a narrow one. This concept is known as **resistance** and is generally true for electrical wires or plumbing, just as it is true for axons, although the specific conditions are different at the scales of electrons or ions versus water in a river.

Note:**Homeostatic Imbalances****Potassium Concentration**

Glial cells, especially astrocytes, are responsible for maintaining the chemical environment of the CNS tissue. The concentrations of ions in the extracellular fluid are the basis for how the membrane potential is

established and changes in electrochemical signaling. If the balance of ions is upset, drastic outcomes are possible.

Normally the concentration of K^+ is higher inside the neuron than outside. After the repolarizing phase of the action potential, K^+ leakage channels and the Na^+/K^+ pump ensure that the ions return to their original locations. Following a stroke or other ischemic event, extracellular K^+ levels are elevated. The astrocytes in the area are equipped to clear excess K^+ to aid the pump. But when the level is far out of balance, the effects can be irreversible.

Astrocytes can become reactive in cases such as these, which impairs their ability to maintain the local chemical environment. The glial cells enlarge and their processes swell. They lose their K^+ buffering ability and the function of the pump is affected, or even reversed. One of the early signs of cell disease is this "leaking" of sodium ions into the body cells. This sodium/potassium imbalance negatively affects the internal chemistry of cells, preventing them from functioning normally.

Note:



Visit this [site](#) to see a virtual neurophysiology lab, and to observe electrophysiological processes in the nervous system, where scientists directly measure the electrical signals produced by neurons. Often, the action potentials occur so rapidly that watching a screen to see them occur is not helpful. A speaker is powered by the signals recorded from a neuron and it “pops” each time the neuron fires an action potential. These action potentials are firing so fast that it sounds like static on the radio. Electrophysiologists can recognize the patterns within that static to understand what is happening. Why is the leech model used for measuring the electrical activity of neurons instead of using humans?

Chapter Review

The nervous system is characterized by electrical signals that are sent from one area to another. Whether those areas are close or very far apart, the signal must travel along an axon. The basis of the electrical signal is the controlled distribution of ions across the membrane. Transmembrane ion channels regulate when ions can move in or out of the cell, so that a precise signal is generated. This signal is the action potential which has a very characteristic shape based on voltage changes across the membrane in a given time period.

The membrane is normally at rest with established Na^+ and K^+ concentrations on either side. A stimulus will start the depolarization of the membrane, and voltage-gated channels will result in further depolarization followed by repolarization of the membrane. A slight overshoot of hyperpolarization marks the end of the action potential. While an action potential is in progress, another cannot be generated under the same conditions. While the voltage-gated Na^+ channel is inactivated, absolutely no action potentials can be generated. Once that channel has returned to its resting state, a new action potential is possible, but it must be started by a relatively stronger stimulus to overcome the K^+ leaving the cell.

The action potential travels down the axon as voltage-gated ion channels are opened by the spreading depolarization. In unmyelinated axons, this happens in a continuous fashion because there are voltage-gated channels throughout the membrane. In myelinated axons, propagation is described as saltatory because voltage-gated channels are only found at the nodes of Ranvier and the electrical events seem to “jump” from one node to the next. Saltatory conduction is faster than continuous conduction, meaning that myelinated axons propagate their signals faster. The diameter of the axon also makes a difference as ions diffusing within the cell have less resistance in a wider space.

Interactive Link Questions

Exercise:

Problem:

What happens across the membrane of an electrically active cell is a dynamic process that is hard to visualize with static images or through text descriptions. View this [animation](#) to really understand the process. What is the difference between the driving force for Na^+ and K^+ ? And what is similar about the movement of these two ions?

Solution:

Sodium is moving into the cell because of the immense concentration gradient, whereas potassium is moving out because of the depolarization that sodium causes. However, they both move down their respective gradients, toward equilibrium.

Exercise:**Problem:**

Visit this [site](#) to see a virtual neurophysiology lab, and to observe electrophysiological processes in the nervous system, where scientists directly measure the electrical signals produced by neurons. Often, the action potentials occur so rapidly that watching a screen to see them occur is not helpful. A speaker is powered by the signals recorded from a neuron and it “pops” each time the neuron fires an action potential. These action potentials are firing so fast that it sounds like static on the radio. Electrophysiologists can recognize the patterns within that static to understand what is happening. Why is the leech model used for measuring the electrical activity of neurons instead of using humans?

Solution:

The properties of electrophysiology are common to all animals, so using the leech is an easier, more humane approach to studying the properties of these cells. There are differences between the nervous systems of invertebrates (such as a leech) and vertebrates, but not for the sake of what these experiments study.

Review Questions

Exercise:

Problem:

What ion enters a neuron causing depolarization of the cell membrane?

- a. sodium
- b. chloride
- c. potassium
- d. phosphate

Solution:

A

Exercise:

Problem: Voltage-gated Na^+ channels open upon reaching what state?

- a. resting potential
- b. threshold
- c. repolarization
- d. overshoot

Solution:

B

Exercise:

Problem: What does a ligand-gated channel require in order to open?

- a. increase in concentration of Na^+ ions
- b. binding of a neurotransmitter
- c. increase in concentration of K^+ ions

d. depolarization of the membrane

Solution:

B

Exercise:

Problem: What does a mechanically gated channel respond to?

- a. physical stimulus
 - b. chemical stimulus
 - c. increase in resistance
 - d. decrease in resistance
-

Solution:

A

Exercise:

Problem:

Which of the following voltages would most likely be measured during the relative refractory period?

- a. +30 mV
 - b. 0 mV
 - c. -45 mV
 - d. -80 mv
-

Solution:

D

Exercise:

Problem:

Which of the following is probably going to propagate an action potential fastest?

- a. a thin, unmyelinated axon
- b. a thin, myelinated axon
- c. a thick, unmyelinated axon
- d. a thick, myelinated axon

Solution:

D

Critical Thinking Questions**Exercise:****Problem:**

What does it mean for an action potential to be an “all or none” event?

Solution:

The cell membrane must reach threshold before voltage-gated Na^+ channels open. If threshold is not reached, those channels do not open, and the depolarizing phase of the action potential does not occur, the cell membrane will just go back to its resting state.

Exercise:**Problem:**

The conscious perception of pain is often delayed because of the time it takes for the sensations to reach the cerebral cortex. Why would this be the case based on propagation of the axon potential?

Solution:

Axons of pain sensing sensory neurons are thin and unmyelinated so that it takes longer for that sensation to reach the brain than other sensations.

Glossary

absolute refractory period

time during an action period when another action potential cannot be generated because the voltage-gated Na^+ channel is inactivated

activation gate

part of the voltage-gated Na^+ channel that opens when the membrane voltage reaches threshold

continuous conduction

slow propagation of an action potential along an unmyelinated axon owing to voltage-gated Na^+ channels located along the entire length of the cell membrane

depolarization

change in a cell membrane potential from rest toward zero

electrochemical exclusion

principle of selectively allowing ions through a channel on the basis of their charge

excitable membrane

cell membrane that regulates the movement of ions so that an electrical signal can be generated

gated

property of a channel that determines how it opens under specific conditions, such as voltage change or physical deformation

inactivation gate

part of a voltage-gated Na^+ channel that closes when the membrane potential reaches $+30 \text{ mV}$

ionotropic receptor

neurotransmitter receptor that acts as an ion channel gate, and opens by the binding of the neurotransmitter

leakage channel

ion channel that opens randomly and is not gated to a specific event, also known as a non-gated channel

ligand-gated channels

another name for an ionotropic receptor for which a neurotransmitter is the ligand

mechanically gated channel

ion channel that opens when a physical event directly affects the structure of the protein

membrane potential

distribution of charge across the cell membrane, based on the charges of ions

nonspecific channel

channel that is not specific to one ion over another, such as a nonspecific cation channel that allows any positively charged ion across the membrane

refractory period

time after the initiation of an action potential when another action potential cannot be generated

relative refractory period

time during the refractory period when a new action potential can only be initiated by a stronger stimulus than the current action potential because voltage-gated K^+ channels are not closed

repolarization

return of the membrane potential to its normally negative voltage at the end of the action potential

resistance

property of an axon that relates to the ability of particles to diffuse through the cytoplasm; this is inversely proportional to the fiber diameter

resting membrane potential

the difference in voltage measured across a cell membrane under steady-state conditions, typically -70 mV

saltatory conduction

quick propagation of the action potential along a myelinated axon owing to voltage-gated Na^+ channels being present only at the nodes of Ranvier

size exclusion

principle of selectively allowing ions through a channel on the basis of their relative size

voltage-gated channel

ion channel that opens because of a change in the charge distributed across the membrane where it is located

Communication Between Neurons

By the end of this section, you will be able to:

- Explain the differences between the types of graded potentials
- Categorize the major neurotransmitters by chemical type and effect

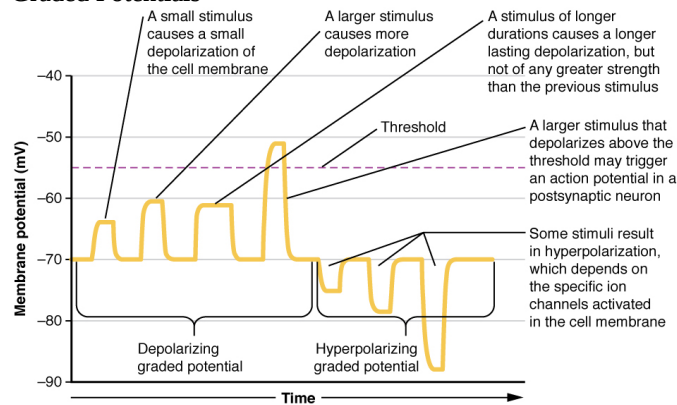
The electrical changes taking place within a neuron, as described in the previous section, are similar to a light switch being turned on. A stimulus starts the depolarization, but the action potential runs on its own once a threshold has been reached. The question is now, “What flips the light switch on?” Temporary changes to the cell membrane voltage can result from neurons receiving information from the environment, or from the action of one neuron on another. These special types of potentials influence a neuron and determine whether an action potential will occur or not. Many of these transient signals originate at the synapse.

Graded Potentials

Local changes in the membrane potential are called graded potentials and are usually associated with the dendrites of a neuron. The amount of change in the membrane potential is determined by the size of the stimulus that causes it. In the example of testing the temperature of the shower, slightly warm water would only initiate a small change in a thermoreceptor, whereas hot water would cause a large amount of change in the membrane potential.

Graded potentials can be of two sorts, either they are depolarizing or hyperpolarizing ([link](#)). For a membrane at the resting potential, a graded potential represents a change in that voltage either above -70 mV or below -70 mV. Depolarizing graded potentials are often the result of Na^+ or Ca^{2+} entering the cell. Both of these ions have higher concentrations outside the cell than inside; because they have a positive charge, they will move into the cell causing it to become less negative relative to the outside. Hyperpolarizing graded potentials can be caused by K^+ leaving the cell or Cl^- entering the cell. If a positive charge moves out of a cell, the cell becomes more negative; if a negative charge enters the cell, the same thing happens.

Graded Potentials



Graded potentials are temporary changes in the membrane voltage, the characteristics of which depend on the size of the stimulus. Some types of stimuli cause depolarization of the membrane, whereas others cause hyperpolarization. It depends on the specific ion channels that are activated in the cell membrane.

Types of Graded Potentials

For the unipolar cells of sensory neurons—both those with free nerve endings and those within encapsulations—graded potentials develop in the dendrites that influence the generation of an action potential in the axon of the same cell. This is called a **generator potential**. For other sensory receptor cells, such as taste cells or photoreceptors of the retina, graded potentials in their membranes result in the release of neurotransmitters at synapses with sensory neurons. This is called a **receptor potential**.

A **postsynaptic potential (PSP)** is the graded potential in the dendrites of a neuron that is receiving synapses from other cells. Postsynaptic potentials can be depolarizing or hyperpolarizing. Depolarization in a postsynaptic potential is called an **excitatory postsynaptic potential (EPSP)** because it causes the membrane potential to move toward threshold. Hyperpolarization in a postsynaptic potential is an **inhibitory postsynaptic potential (IPSP)** because it causes the membrane potential to move away from threshold.

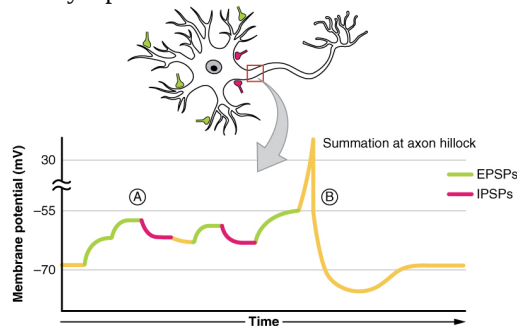
Summation

All types of graded potentials will result in small changes of either depolarization or hyperpolarization in the voltage of a membrane. These changes can lead to the neuron reaching threshold if the changes add together, or **summate**. The combined effects of different types of graded potentials are illustrated in [\[link\]](#). If the total change in voltage in the membrane is a positive 15 mV, meaning that the membrane depolarizes from -70 mV to -55 mV, then the graded potentials will result in the membrane reaching threshold.

For receptor potentials, threshold is not a factor because the change in membrane potential for receptor cells directly causes neurotransmitter release. However, generator potentials can initiate action potentials in the sensory neuron axon, and postsynaptic potentials can initiate an action potential in the axon of other neurons. Graded potentials summate at a specific location at the beginning of the axon to initiate the action potential, namely the initial segment. For sensory neurons, which do not have a cell body between the dendrites and the axon, the initial segment is directly adjacent to the dendritic endings. For all other neurons, the axon hillock is essentially the initial segment of the axon, and it is where summation takes place. These locations have a high density of voltage-gated Na^+ channels that initiate the depolarizing phase of the action potential.

Summation can be spatial or temporal, meaning it can be the result of multiple graded potentials at different locations on the neuron, or all at the same place but separated in time. **Spatial summation** is related to associating the activity of multiple inputs to a neuron with each other. **Temporal summation** is the relationship of multiple action potentials from a single cell resulting in a significant change in the membrane potential. Spatial and temporal summation can act together, as well.

Postsynaptic Potential Summation



The result of summation of postsynaptic potentials is the overall change in the membrane potential. At point A, several different excitatory postsynaptic potentials add up to a large depolarization. At point B, a mix of excitatory and inhibitory postsynaptic

potentials result in a different end result for the membrane potential.

Note:



Watch this [video](#) to learn about summation. The process of converting electrical signals to chemical signals and back requires subtle changes that can result in transient increases or decreases in membrane voltage. To cause a lasting change in the target cell, multiple signals are usually added together, or summated. Does spatial summation have to happen all at once, or can the separate signals arrive on the postsynaptic neuron at slightly different times? Explain your answer.

Synapses

There are two types of connections between electrically active cells, chemical synapses and electrical synapses. In a **chemical synapse**, a chemical signal—namely, a neurotransmitter—is released from one cell and it affects the other cell. In an **electrical synapse**, there is a direct connection between the two cells so that ions can pass directly from one cell to the next. If one cell is depolarized in an electrical synapse, the joined cell also depolarizes because the ions pass between the cells. Chemical synapses involve the transmission of chemical information from one cell to the next. This section will concentrate on the chemical type of synapse.

An example of a chemical synapse is the neuromuscular junction (NMJ) described in the chapter on muscle tissue. In the nervous system, there are many more synapses that are essentially the same as the NMJ. All synapses have common characteristics, which can be summarized in this list:

- presynaptic element
- neurotransmitter (packaged in vesicles)
- synaptic cleft
- receptor proteins
- postsynaptic element
- neurotransmitter elimination or re-uptake

For the NMJ, these characteristics are as follows: the presynaptic element is the motor neuron's axon terminals, the neurotransmitter is acetylcholine, the synaptic cleft is the space between the cells where the neurotransmitter diffuses, the receptor protein is the nicotinic acetylcholine receptor, the postsynaptic element is the sarcolemma of the muscle cell, and the neurotransmitter is eliminated by acetylcholinesterase. Other synapses are similar to this, and the specifics are different, but they all contain the same characteristics.

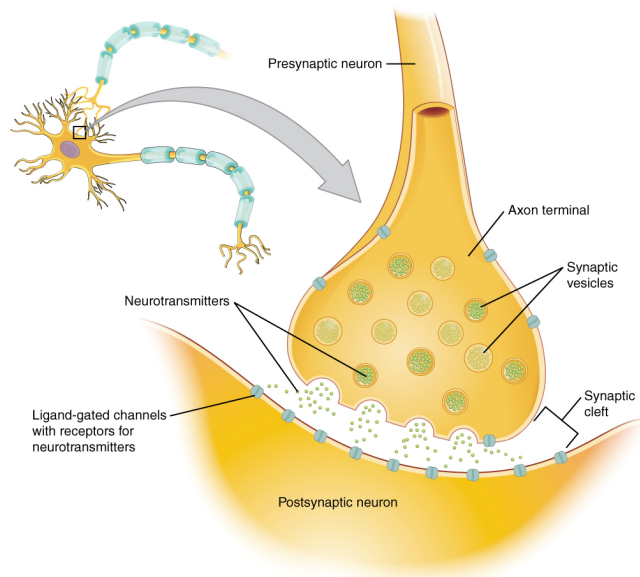
Neurotransmitter Release

When an action potential reaches the axon terminals, voltage-gated Ca^{2+} channels in the membrane of the synaptic end bulb open. The concentration of Ca^{2+} increases inside the end bulb, and the Ca^{2+} ion associates with proteins in the outer surface of neurotransmitter vesicles. The Ca^{2+} facilitates the merging of the vesicle with the

presynaptic membrane so that the neurotransmitter is released through exocytosis into the small gap between the cells, known as the **synaptic cleft**.

Once in the synaptic cleft, the neurotransmitter diffuses the short distance to the postsynaptic membrane and can interact with neurotransmitter receptors. Receptors are specific for the neurotransmitter, and the two fit together like a key and lock. One neurotransmitter binds to its receptor and will not bind to receptors for other neurotransmitters, making the binding a specific chemical event ([\[link\]](#)).

The Synapse



The synapse is a connection between a neuron and its target cell (which is not necessarily a neuron). The presynaptic element is the synaptic end bulb of the axon where Ca^{2+} enters the bulb to cause vesicle fusion and neurotransmitter release. The neurotransmitter diffuses across the synaptic cleft to bind to its receptor. The neurotransmitter is cleared from the synapse either by enzymatic degradation, neuronal reuptake, or glial reuptake.

Neurotransmitter Systems

There are several systems of neurotransmitters that are found at various synapses in the nervous system. These groups refer to the chemicals that are the neurotransmitters, and within the groups are specific systems.

The first group, which is a neurotransmitter system of its own, is the **cholinergic system**. It is the system based on acetylcholine. This includes the NMJ as an example of a cholinergic synapse, but cholinergic synapses are found in other parts of the nervous system. They are in the autonomic nervous system, as well as distributed throughout the brain.

The cholinergic system has two types of receptors, the **nicotinic receptor** is found in the NMJ as well as other synapses. There is also an acetylcholine receptor known as the **muscarinic receptor**. Both of these receptors are named for drugs that interact with the receptor in addition to acetylcholine. Nicotine will bind to the nicotinic receptor and activate it similar to acetylcholine. Muscarine, a product of certain mushrooms, will bind to the

muscarinic receptor. However, nicotine will not bind to the muscarinic receptor and muscarine will not bind to the nicotinic receptor.

Another group of neurotransmitters are amino acids. This includes glutamate (Glu), GABA (gamma-aminobutyric acid, a derivative of glutamate), and glycine (Gly). These amino acids have an amino group and a carboxyl group in their chemical structures. Glutamate is one of the 20 amino acids that are used to make proteins. Each amino acid neurotransmitter would be part of its own system, namely the glutamatergic, GABAergic, and glycinergic systems. They each have their own receptors and do not interact with each other. Amino acid neurotransmitters are eliminated from the synapse by reuptake. A pump in the cell membrane of the presynaptic element, or sometimes a neighboring glial cell, will clear the amino acid from the synaptic cleft so that it can be recycled, repackaged in vesicles, and released again.

Another class of neurotransmitter is the **biogenic amine**, a group of neurotransmitters that are enzymatically made from amino acids. They have amino groups in them, but no longer have carboxyl groups and are therefore no longer classified as amino acids. Serotonin is made from tryptophan. It is the basis of the serotonergic system, which has its own specific receptors. Serotonin is transported back into the presynaptic cell for repackaging.

Other biogenic amines are made from tyrosine, and include dopamine, norepinephrine, and epinephrine. Dopamine is part of its own system, the dopaminergic system, which has dopamine receptors. Dopamine is removed from the synapse by transport proteins in the presynaptic cell membrane. Norepinephrine and epinephrine belong to the adrenergic neurotransmitter system. The two molecules are very similar and bind to the same receptors, which are referred to as alpha and beta receptors. Norepinephrine and epinephrine are also transported back into the presynaptic cell. The chemical epinephrine (epi- = “on”; “-nephrine” = kidney) is also known as adrenaline (renal = “kidney”), and norepinephrine is sometimes referred to as noradrenaline. The adrenal gland produces epinephrine and norepinephrine to be released into the blood stream as hormones.

A **neuropeptide** is a neurotransmitter molecule made up of chains of amino acids connected by peptide bonds. This is what a protein is, but the term protein implies a certain length to the molecule. Some neuropeptides are quite short, such as met-enkephalin, which is five amino acids long. Others are long, such as beta-endorphin, which is 31 amino acids long. Neuropeptides are often released at synapses in combination with another neurotransmitter, and they often act as hormones in other systems of the body, such as vasoactive intestinal peptide (VIP) or substance P.

The effect of a neurotransmitter on the postsynaptic element is entirely dependent on the receptor protein. First, if there is no receptor protein in the membrane of the postsynaptic element, then the neurotransmitter has no effect. The depolarizing or hyperpolarizing effect is also dependent on the receptor. When acetylcholine binds to the nicotinic receptor, the postsynaptic cell is depolarized. This is because the receptor is a cation channel and positively charged Na^+ will rush into the cell. However, when acetylcholine binds to the muscarinic receptor, of which there are several variants, it might cause depolarization or hyperpolarization of the target cell.

The amino acid neurotransmitters, glutamate, glycine, and GABA, are almost exclusively associated with just one effect. Glutamate is considered an excitatory amino acid, but only because Glu receptors in the adult cause depolarization of the postsynaptic cell. Glycine and GABA are considered inhibitory amino acids, again because their receptors cause hyperpolarization.

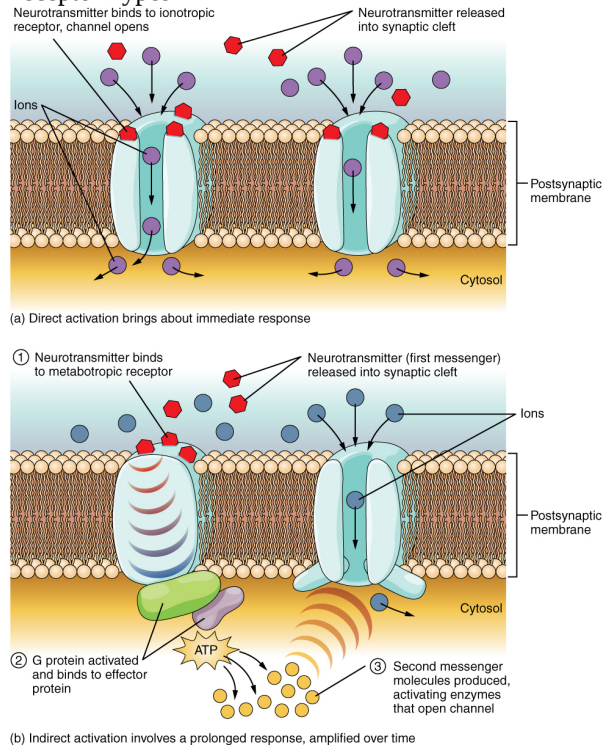
The biogenic amines have mixed effects. For example, the dopamine receptors that are classified as D1 receptors are excitatory whereas D2-type receptors are inhibitory. Biogenic amine receptors and neuropeptide receptors can have even more complex effects because some may not directly affect the membrane potential, but rather have an effect on gene transcription or other metabolic processes in the neuron. The characteristics of the various neurotransmitter systems presented in this section are organized in [\[link\]](#).

The important thing to remember about neurotransmitters, and signaling chemicals in general, is that the effect is entirely dependent on the receptor. Neurotransmitters bind to one of two classes of receptors at the cell surface, ionotropic or metabotropic ([\[link\]](#)). Ionotropic receptors are ligand-gated ion channels, such as the nicotinic receptor for acetylcholine or the glycine receptor. A **metabotropic receptor** involves a complex of proteins that result in metabolic changes within the cell. The receptor complex includes the transmembrane receptor protein, a G protein, and an effector protein. The neurotransmitter, referred to as the first messenger, binds to the receptor

protein on the extracellular surface of the cell, and the intracellular side of the protein initiates activity of the G protein. The **G protein** is a guanosine triphosphate (GTP) hydrolase that physically moves from the receptor protein to the effector protein to activate the latter. An **effector protein** is an enzyme that catalyzes the generation of a new molecule, which acts as the intracellular mediator of the signal that binds to the receptor. This intracellular mediator is called the second messenger.

Different receptors use different second messengers. Two common examples of second messengers are cyclic adenosine monophosphate (cAMP) and inositol triphosphate (IP₃). The enzyme adenylate cyclase (an example of an effector protein) makes cAMP, and phospholipase C is the enzyme that makes IP₃. Second messengers, after they are produced by the effector protein, cause metabolic changes within the cell. These changes are most likely the activation of other enzymes in the cell. In neurons, they often modify ion channels, either opening or closing them. These enzymes can also cause changes in the cell, such as the activation of genes in the nucleus, and therefore the increased synthesis of proteins. In neurons, these kinds of changes are often the basis of stronger connections between cells at the synapse and may be the basis of learning and memory.

Receptor Types



- (a) An ionotropic receptor is a channel that opens when the neurotransmitter binds to it. (b) A metabotropic receptor is a complex that causes metabolic changes in the cell when the neurotransmitter binds to it (1). After binding, the G protein hydrolyzes GTP and moves to the effector protein (2). When the G protein contacts the effector protein, a second messenger is generated, such as cAMP (3). The second messenger can then go on to cause changes in the neuron, such as opening or closing ion channels, metabolic changes, and changes in gene transcription.

Note:

Watch this [video](#) to learn about the release of a neurotransmitter. The action potential reaches the end of the axon, called the axon terminal, and a chemical signal is released to tell the target cell to do something—either to initiate a new action potential, or to suppress that activity. In a very short space, the electrical signal of the action potential is changed into the chemical signal of a neurotransmitter and then back to electrical changes in the target cell membrane. What is the importance of voltage-gated calcium channels in the release of neurotransmitters?

Characteristics of Neurotransmitter Systems				
System	Cholinergic	Amino acids	Biogenic amines	Neuropeptides
Neurotransmitters	Acetylcholine	Glutamate, glycine, GABA	Serotonin (5-HT), dopamine, norepinephrine, (epinephrine)	Met-enkephalin, beta-endorphin, VIP, Substance P etc.
Receptors	Nicotinic and muscarinic receptors	Glu receptors, gly receptors, GABA receptors	5-HT receptors, D1 and D2 receptors, α -adrenergic and β -adrenergic receptors	Receptors are too numerous to list, but are specific to the peptides.
Elimination	Degradation by acetylcholinesterase	Reuptake by neurons or glia	Reuptake by neurons	Degradation by enzymes called peptidases
Postsynaptic effect	Nicotinic receptor causes depolarization. Muscarinic receptors can cause both depolarization or hyperpolarization depending on the subtype.	Glu receptors cause depolarization. Gly and GABA receptors cause hyperpolarization.	Depolarization or hyperpolarization depends on the specific receptor. For example, D1 receptors cause depolarization and D2 receptors cause hyperpolarization.	Depolarization or hyperpolarization depends on the specific receptor.

Note:

Disorders of the...
Nervous System

The underlying cause of some neurodegenerative diseases, such as Alzheimer's and Parkinson's, appears to be related to proteins—specifically, to proteins behaving badly. One of the strongest theories of what causes Alzheimer's disease is based on the accumulation of beta-amyloid plaques, dense conglomerations of a protein that is not functioning correctly. Parkinson's disease is linked to an increase in a protein known as alpha-synuclein that is toxic to the cells of the substantia nigra nucleus in the midbrain.

For proteins to function correctly, they are dependent on their three-dimensional shape. The linear sequence of amino acids folds into a three-dimensional shape that is based on the interactions between and among those amino acids. When the folding is disturbed, and proteins take on a different shape, they stop functioning correctly. But the disease is not necessarily the result of functional loss of these proteins; rather, these altered proteins start to accumulate and may become toxic. For example, in Alzheimer's, the hallmark of the disease is the accumulation of these amyloid plaques in the cerebral cortex. The term coined to describe this sort of disease is “proteopathy” and it includes other diseases. Creutzfeld-Jacob disease, the human variant of the prion disease known as mad cow disease in the bovine, also involves the accumulation of amyloid plaques, similar to Alzheimer's. Diseases of other organ systems can fall into this group as well, such as cystic fibrosis or type 2 diabetes. Recognizing the relationship between these diseases has suggested new therapeutic possibilities. Interfering with the accumulation of the proteins, and possibly as early as their original production within the cell, may unlock new ways to alleviate these devastating diseases.

Chapter Review

The basis of the electrical signal within a neuron is the action potential that propagates down the axon. For a neuron to generate an action potential, it needs to receive input from another source, either another neuron or a sensory stimulus. That input will result in opening ion channels in the neuron, resulting in a graded potential based on the strength of the stimulus. Graded potentials can be depolarizing or hyperpolarizing and can summate to affect the probability of the neuron reaching threshold.

Graded potentials can be the result of sensory stimuli. If the sensory stimulus is received by the dendrites of a unipolar sensory neuron, such as the sensory neuron ending in the skin, the graded potential is called a generator potential because it can directly generate the action potential in the initial segment of the axon. If the sensory stimulus is received by a specialized sensory receptor cell, the graded potential is called a receptor potential. Graded potentials produced by interactions between neurons at synapses are called postsynaptic potentials (PSPs). A depolarizing graded potential at a synapse is called an excitatory PSP, and a hyperpolarizing graded potential at a synapse is called an inhibitory PSP.

Synapses are the contacts between neurons, which can either be chemical or electrical in nature. Chemical synapses are far more common. At a chemical synapse, neurotransmitter is released from the presynaptic element and diffuses across the synaptic cleft. The neurotransmitter binds to a receptor protein and causes a change in the postsynaptic membrane (the PSP). The neurotransmitter must be inactivated or removed from the synaptic cleft so that the stimulus is limited in time.

The particular characteristics of a synapse vary based on the neurotransmitter system produced by that neuron. The cholinergic system is found at the neuromuscular junction and in certain places within the nervous system. Amino acids, such as glutamate, glycine, and gamma-aminobutyric acid (GABA) are used as neurotransmitters. Other neurotransmitters are the result of amino acids being enzymatically changed, as in the biogenic amines, or being covalently bonded together, as in the neuropeptides.

Interactive Link Questions

Exercise:

Problem:

Watch this [video](#) to learn about summation. The process of converting electrical signals to chemical signals and back requires subtle changes that can result in transient increases or decreases in membrane voltage. To cause a lasting change in the target cell, multiple signals are usually added together, or summated. Does spatial summation have to happen all at once, or can the separate signals arrive on the postsynaptic neuron at slightly different times? Explain your answer.

Solution:

A second signal from a separate presynaptic neuron can arrive slightly later, as long as it arrives before the first one dies off, or dissipates.

Exercise:**Problem:**

Watch this [video](#) to learn about the release of a neurotransmitter. The action potential reaches the end of the axon, called the axon terminal, and a chemical signal is released to tell the target cell to do something, either initiate a new action potential, or to suppress that activity. In a very short space, the electrical signal of the action potential is changed into the chemical signal of a neurotransmitter, and then back to electrical changes in the target cell membrane. What is the importance of voltage-gated calcium channels in the release of neurotransmitters?

Solution:

The action potential depolarizes the cell membrane of the axon terminal, which contains the voltage-gated Ca^{2+} channel. That voltage change opens the channel so that Ca^{2+} can enter the axon terminal. Calcium ions make it possible for synaptic vesicles to release their contents through exocytosis.

Review Questions**Exercise:****Problem:**

How much of a change in the membrane potential is necessary for the summation of postsynaptic potentials to result in an action potential being generated?

- a. +30 mV
 - b. +15 mV
 - c. +10 mV
 - d. -15 mV
-

Solution:

B

Exercise:**Problem:**

A channel opens on a postsynaptic membrane that causes a negative ion to enter the cell. What type of graded potential is this?

- a. depolarizing
- b. repolarizing
- c. hyperpolarizing

d. non-polarizing

Solution:

C

Exercise:

Problem: What neurotransmitter is released at the neuromuscular junction?

- a. norepinephrine
- b. serotonin
- c. dopamine
- d. acetylcholine

Solution:

D

Exercise:

Problem: What type of receptor requires an effector protein to initiate a signal?

- a. biogenic amine
- b. ionotropic receptor
- c. cholinergic system
- d. metabotropic receptor

Solution:

D

Exercise:

Problem: Which of the following neurotransmitters is associated with inhibition exclusively?

- a. GABA
- b. acetylcholine
- c. glutamate
- d. norepinephrine

Solution:

A

Critical Thinking Questions

Exercise:

Problem:

If a postsynaptic cell has synapses from five different cells, and three cause EPSPs and two of them cause IPSPs, give an example of a series of depolarizations and hyperpolarizations that would result in the neuron reaching threshold.

Solution:

EPSP1 = +5 mV, EPSP2 = +7 mV, EPSP 3 = +10 mV, IPSP1 = -4 mV, IPSP2 = -3 mV. $5 + 7 + 10 - 4 - 3 = +15$ mV.

Exercise:**Problem:**

Why is the receptor the important element determining the effect a neurotransmitter has on a target cell?

Solution:

Different neurotransmitters have different receptors. Thus, the type of receptor in the postsynaptic cell is what determines which ion channels open. Acetylcholine binding to the nicotinic receptor causes cations to cross the membrane. GABA binding to its receptor causes the anion chloride to cross the membrane.

Glossary**biogenic amine**

class of neurotransmitters that are enzymatically derived from amino acids but no longer contain a carboxyl group

chemical synapse

connection between two neurons, or between a neuron and its target, where a neurotransmitter diffuses across a very short distance

cholinergic system

neurotransmitter system of acetylcholine, which includes its receptors and the enzyme acetylcholinesterase

effector protein

enzyme that catalyzes the generation of a new molecule, which acts as the intracellular mediator of the signal that binds to the receptor

electrical synapse

connection between two neurons, or any two electrically active cells, where ions flow directly through channels spanning their adjacent cell membranes

excitatory postsynaptic potential (EPSP)

graded potential in the postsynaptic membrane that is the result of depolarization and makes an action potential more likely to occur

generator potential

graded potential from dendrites of a unipolar cell which generates the action potential in the initial segment of that cell's axon

G protein

guanosine triphosphate (GTP) hydrolase that physically moves from the receptor protein to the effector protein to activate the latter

inhibitory postsynaptic potential (IPSP)

graded potential in the postsynaptic membrane that is the result of hyperpolarization and makes an action potential less likely to occur

metabotropic receptor

neurotransmitter receptor that involves a complex of proteins that cause metabolic changes in a cell

muscarinic receptor

type of acetylcholine receptor protein that is characterized by also binding to muscarine and is a metabotropic receptor

neuropeptide

neurotransmitter type that includes protein molecules and shorter chains of amino acids

nicotinic receptor

type of acetylcholine receptor protein that is characterized by also binding to nicotine and is an ionotropic receptor

postsynaptic potential (PSP)

graded potential in the postsynaptic membrane caused by the binding of neurotransmitter to protein receptors

receptor potential

graded potential in a specialized sensory cell that directly causes the release of neurotransmitter without an intervening action potential

spatial summation

combination of graded potentials across the neuronal cell membrane caused by signals from separate presynaptic elements that add up to initiate an action potential

summate

to add together, as in the cumulative change in postsynaptic potentials toward reaching threshold in the membrane, either across a span of the membrane or over a certain amount of time

synaptic cleft

small gap between cells in a chemical synapse where neurotransmitter diffuses from the presynaptic element to the postsynaptic element

temporal summation

combination of graded potentials at the same location on a neuron resulting in a strong signal from one input

The Central Nervous System

By the end of this section, you will be able to:

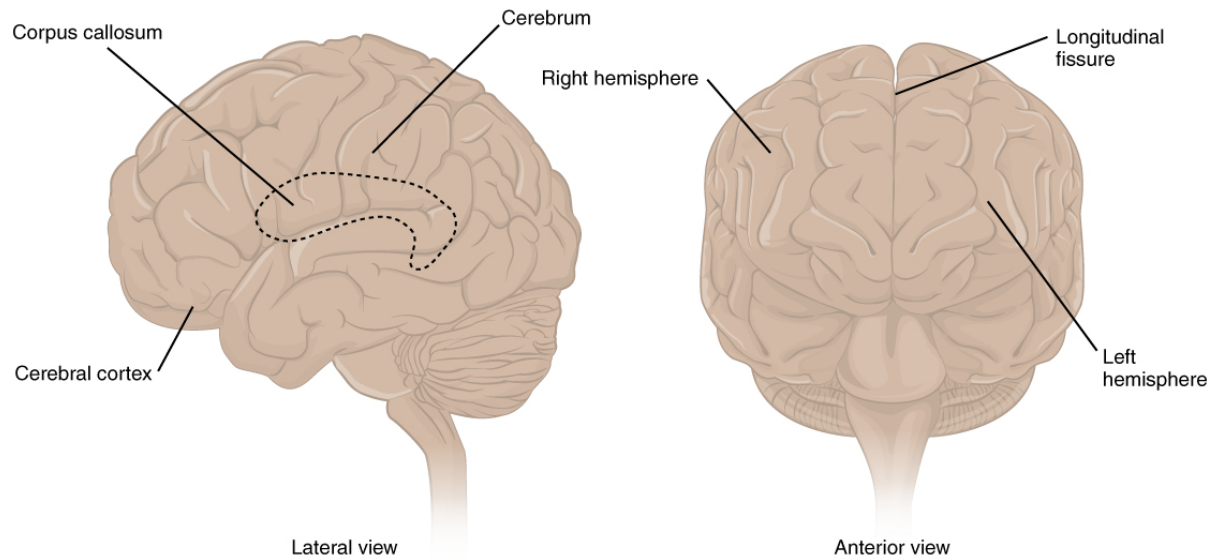
- Name the major regions of the adult brain
- Describe the connections between the cerebrum and brain stem through the diencephalon, and from those regions into the spinal cord
- Recognize the complex connections within the subcortical structures of the basal nuclei
- Explain the arrangement of gray and white matter in the spinal cord

The brain and the spinal cord are the central nervous system, and they represent the main organs of the nervous system. The spinal cord is a single structure, whereas the adult brain is described in terms of four major regions: the cerebrum, the diencephalon, the brain stem, and the cerebellum. A person's conscious experiences are based on neural activity in the brain. The regulation of homeostasis is governed by a specialized region in the brain. The coordination of reflexes depends on the integration of sensory and motor pathways in the spinal cord.

The Cerebrum

The iconic gray mantle of the human brain, which appears to make up most of the mass of the brain, is the **cerebrum** ([\[link\]](#)). The wrinkled portion is the **cerebral cortex**, and the rest of the structure is beneath that outer covering. There is a large separation between the two sides of the cerebrum called the **longitudinal fissure**. It separates the cerebrum into two distinct halves, a right and left **cerebral hemisphere**. Deep within the cerebrum, the white matter of the **corpus callosum** provides the major pathway for communication between the two hemispheres of the cerebral cortex.

The Cerebrum



The cerebrum is a large component of the CNS in humans, and the most obvious aspect of it is the folded surface called the cerebral cortex.

Many of the higher neurological functions, such as memory, emotion, and consciousness, are the result of cerebral function. The complexity of the cerebrum is different across vertebrate species. The cerebrum of the most primitive vertebrates is not much more than the connection for the sense of smell. In mammals, the cerebrum comprises the outer gray matter that is the cortex (from the Latin word meaning “bark of a tree”) and several deep nuclei that belong to three important functional groups. The **basal nuclei** are responsible for cognitive processing, the most important function being that associated with planning movements. The **basal forebrain** contains nuclei that are important in learning and memory. The **limbic cortex** is the region of the cerebral cortex that is part of the **limbic system**, a collection of structures involved in emotion, memory, and behavior.

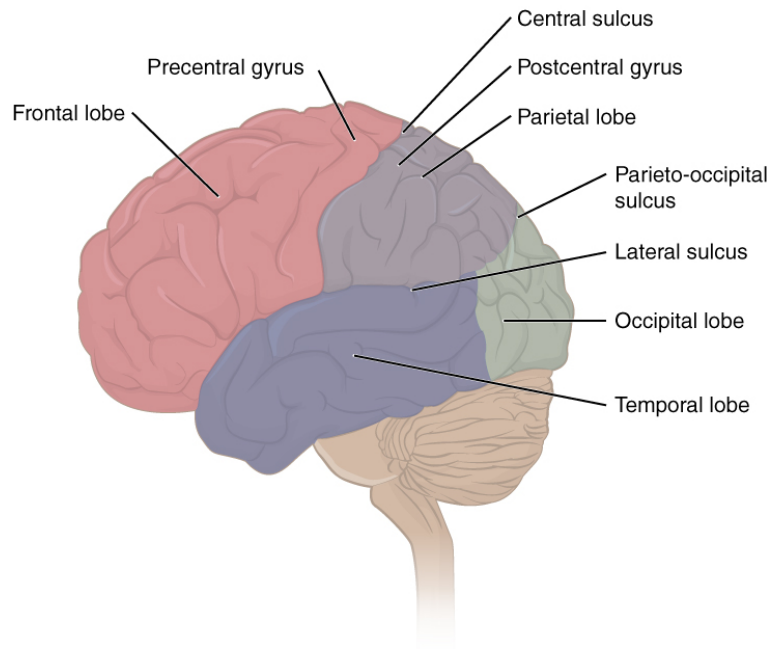
Cerebral Cortex

The cerebrum is covered by a continuous layer of gray matter that wraps around either side of the forebrain—the cerebral cortex. This thin, extensive region of wrinkled gray matter is responsible for the higher functions of the nervous system. A **gyrus** (plural = gyri) is the ridge of one of those wrinkles, and a **sulcus** (plural = sulci) is the groove between two gyri. The pattern of these folds of tissue indicates specific regions of the cerebral cortex.

The head is limited by the size of the birth canal, and the brain must fit inside the cranial cavity of the skull. Extensive folding in the cerebral cortex enables more gray matter to fit into this limited space. If the gray matter of the cortex were peeled off of the cerebrum and laid out flat, its surface area would be roughly equal to one square meter.

The folding of the cortex maximizes the amount of gray matter in the cranial cavity. During embryonic development, as the telencephalon expands within the skull, the brain goes through a regular course of growth that results in everyone's brain having a similar pattern of folds. The surface of the brain can be mapped on the basis of the locations of large gyri and sulci. Using these landmarks, the cortex can be separated into four major regions, or lobes ([\[link\]](#)). The **lateral sulcus** that separates the **temporal lobe** from the other regions is one such landmark. Superior to the lateral sulcus are the **parietal lobe** and **frontal lobe**, which are separated from each other by the **central sulcus**. The posterior region of the cortex is the **occipital lobe**, which has no obvious anatomical border between it and the parietal or temporal lobes on the lateral surface of the brain. From the medial surface, an obvious landmark separating the parietal and occipital lobes is called the **parieto-occipital sulcus**. The fact that there is no obvious anatomical border between these lobes is consistent with the functions of these regions being interrelated.

Lobes of the Cerebral Cortex



The cerebral cortex is divided into four lobes. Extensive folding increases the surface area available for cerebral functions.

Different regions of the cerebral cortex can be associated with particular functions, a concept known as localization of function. In the early 1900s, a German neuroscientist named Korbinian Brodmann performed an extensive study of the microscopic anatomy—the cytoarchitecture—of the cerebral cortex and divided the cortex into 52 separate regions on the basis of the histology of the cortex. His work resulted in a system of classification known as **Brodmann's areas**, which is still used today to describe the anatomical distinctions within the cortex ([\[link\]](#)). The results from Brodmann's work on the anatomy align very well with the functional differences within the cortex. Areas 17 and 18 in the occipital lobe are responsible for primary visual perception. That visual information is complex, so it is processed in the temporal and parietal lobes as well.

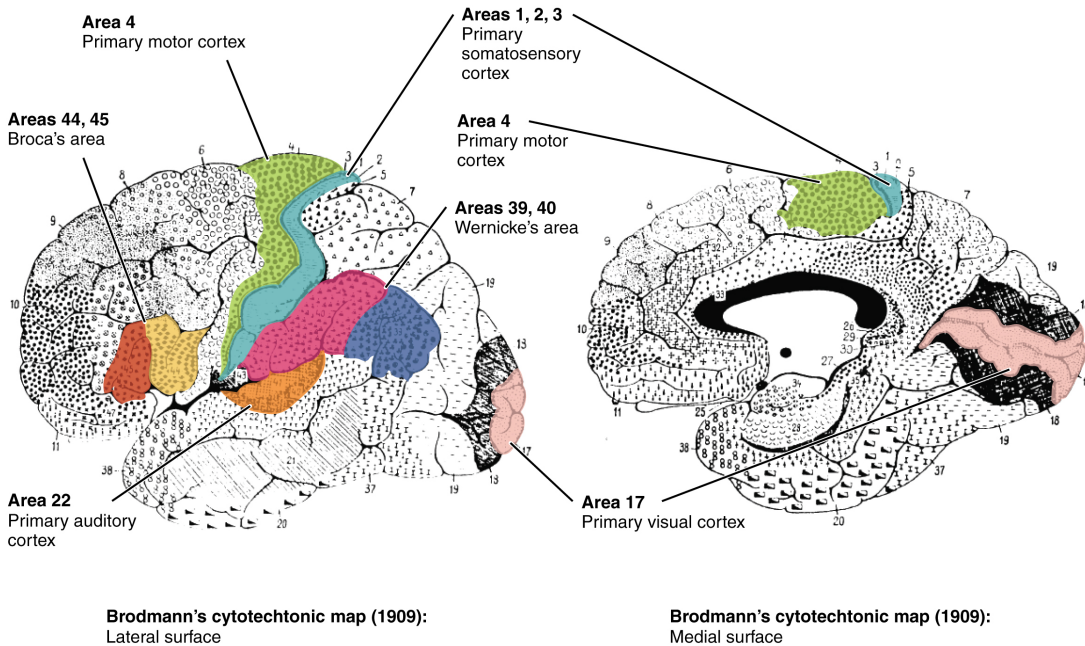
The temporal lobe is associated with primary auditory sensation, known as Brodmann's areas 41 and 42 in the superior temporal lobe. Because regions

of the temporal lobe are part of the limbic system, memory is an important function associated with that lobe. Memory is essentially a sensory function; memories are recalled sensations such as the smell of Mom's baking or the sound of a barking dog. Even memories of movement are really the memory of sensory feedback from those movements, such as stretching muscles or the movement of the skin around a joint. Structures in the temporal lobe are responsible for establishing long-term memory, but the ultimate location of those memories is usually in the region in which the sensory perception was processed.

The main sensation associated with the parietal lobe is **somatosensation**, meaning the general sensations associated with the body. Posterior to the central sulcus is the **postcentral gyrus**, the primary somatosensory cortex, which is identified as Brodmann's areas 1, 2, and 3. All of the tactile senses are processed in this area, including touch, pressure, tickle, pain, itch, and vibration, as well as more general senses of the body such as **proprioception** and **kinesthesia**, which are the senses of body position and movement, respectively.

Anterior to the central sulcus is the frontal lobe, which is primarily associated with motor functions. The **precentral gyrus** is the primary motor cortex. Cells from this region of the cerebral cortex are the upper motor neurons that instruct cells in the spinal cord to move skeletal muscles. Anterior to this region are a few areas that are associated with planned movements. The **premotor area** is responsible for thinking of a movement to be made. The **frontal eye fields** are important in eliciting eye movements and in attending to visual stimuli. **Broca's area** is responsible for the production of language, or controlling movements responsible for speech; in the vast majority of people, it is located only on the left side. Anterior to these regions is the **prefrontal lobe**, which serves cognitive functions that can be the basis of personality, short-term memory, and consciousness. The prefrontal lobotomy is an outdated mode of treatment for personality disorders (psychiatric conditions) that profoundly affected the personality of the patient.

Brodmann's Areas of the Cerebral Cortex



Brodman mapping of functionally distinct regions of the cortex was based on its cytoarchitecture at a microscopic level.

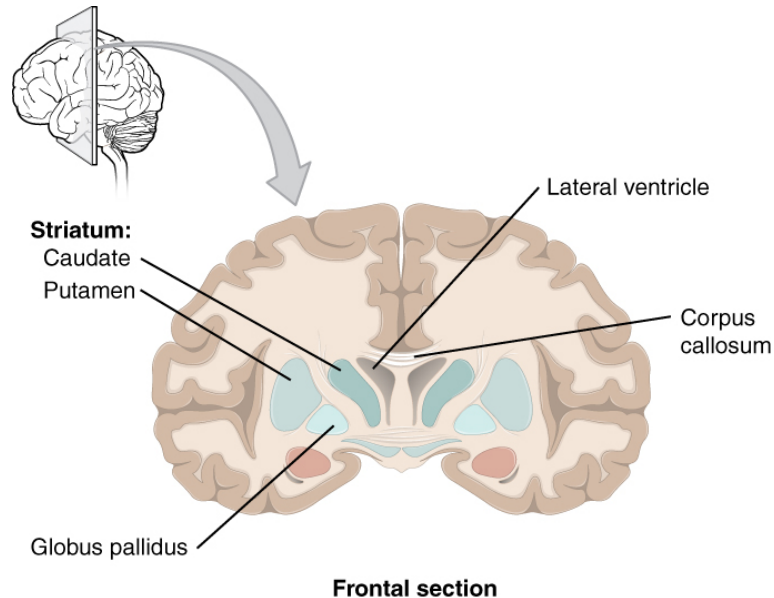
Subcortical structures

Beneath the cerebral cortex are sets of nuclei known as **subcortical nuclei** that augment cortical processes. The nuclei of the basal forebrain serve as the primary location for acetylcholine production, which modulates the overall activity of the cortex, possibly leading to greater attention to sensory stimuli. Alzheimer's disease is associated with a loss of neurons in the basal forebrain. The **hippocampus** and **amygdala** are medial-lobe structures that, along with the adjacent cortex, are involved in long-term memory formation and emotional responses. The basal nuclei are a set of nuclei in the cerebrum responsible for comparing cortical processing with the general state of activity in the nervous system to influence the likelihood of movement taking place. For example, while a student is sitting in a classroom listening to a lecture, the basal nuclei will keep the urge to jump up and scream from actually happening. (The basal nuclei are also referred

to as the basal ganglia, although that is potentially confusing because the term ganglia is typically used for peripheral structures.)

The major structures of the basal nuclei that control movement are the **caudate**, **putamen**, and **globus pallidus**, which are located deep in the cerebrum. The caudate is a long nucleus that follows the basic C-shape of the cerebrum from the frontal lobe, through the parietal and occipital lobes, into the temporal lobe. The putamen is mostly deep in the anterior regions of the frontal and parietal lobes. Together, the caudate and putamen are called the **striatum**. The globus pallidus is a layered nucleus that lies just medial to the putamen; they are called the lenticular nuclei because they look like curved pieces fitting together like lenses. The globus pallidus has two subdivisions, the external and internal segments, which are lateral and medial, respectively. These nuclei are depicted in a frontal section of the brain in [\[link\]](#).

Frontal Section of Cerebral Cortex and Basal Nuclei

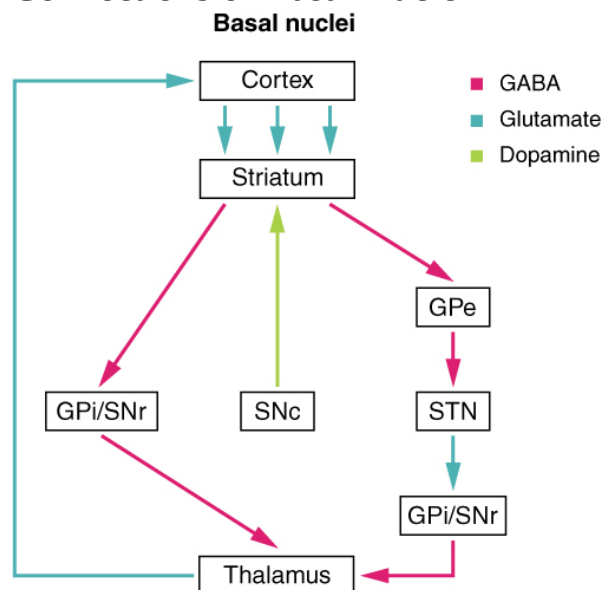


The major components of the basal nuclei, shown in a frontal section of the brain, are the caudate (just lateral to the lateral ventricle), the putamen (inferior to the caudate and separated by the large white-matter structure called the internal

capsule), and the globus pallidus (medial to the putamen).

The basal nuclei in the cerebrum are connected with a few more nuclei in the brain stem that together act as a functional group that forms a motor pathway. Two streams of information processing take place in the basal nuclei. All input to the basal nuclei is from the cortex into the striatum ([\[link\]](#)). The **direct pathway** is the projection of axons from the striatum to the globus pallidus internal segment (GPi) and the **substantia nigra pars reticulata** (SNr). The GPi/SNr then projects to the thalamus, which projects back to the cortex. The **indirect pathway** is the projection of axons from the striatum to the globus pallidus external segment (GPe), then to the subthalamic nucleus (STN), and finally to GPi/SNr. The two streams both target the GPi/SNr, but one has a direct projection and the other goes through a few intervening nuclei. The direct pathway causes the **disinhibition** of the thalamus (inhibition of one cell on a target cell that then inhibits the first cell), whereas the indirect pathway causes, or reinforces, the normal inhibition of the thalamus. The thalamus then can either excite the cortex (as a result of the direct pathway) or fail to excite the cortex (as a result of the indirect pathway).

Connections of Basal Nuclei



Input to the basal nuclei is from the cerebral cortex, which is an

excitatory connection releasing glutamate as a neurotransmitter. This input is to the striatum, or the caudate and putamen. In the direct pathway, the striatum projects to the internal segment of the globus pallidus and the substantia nigra pars reticulata (GPi/SNr). This is an inhibitory pathway, in which GABA is released at the synapse, and the target cells are hyperpolarized and less likely to fire. The output from the basal nuclei is to the thalamus, which is an inhibitory projection using GABA.

The switch between the two pathways is the **substantia nigra pars compacta**, which projects to the striatum and releases the neurotransmitter dopamine. Dopamine receptors are either excitatory (D1-type receptors) or inhibitory (D2-type receptors). The direct pathway is activated by dopamine, and the indirect pathway is inhibited by dopamine. When the substantia nigra pars compacta is firing, it signals to the basal nuclei that the body is in an active state, and movement will be more likely. When the substantia nigra pars compacta is silent, the body is in a passive state, and movement is inhibited. To illustrate this situation, while a student is sitting listening to a lecture, the substantia nigra pars compacta would be silent and the student less likely to get up and walk around. Likewise, while the professor is lecturing, and walking around at the front of the classroom, the professor's substantia nigra pars compacta would be active, in keeping with his or her activity level.

Note:



Watch this [video](#) to learn about the basal nuclei (also known as the basal ganglia), which have two pathways that process information within the cerebrum. As shown in this video, the direct pathway is the shorter pathway through the system that results in increased activity in the cerebral cortex and increased motor activity. The direct pathway is described as resulting in “disinhibition” of the thalamus. What does disinhibition mean? What are the two neurons doing individually to cause this?

Note:



Watch this [video](#) to learn about the basal nuclei (also known as the basal ganglia), which have two pathways that process information within the cerebrum. As shown in this video, the indirect pathway is the longer pathway through the system that results in decreased activity in the cerebral cortex, and therefore less motor activity. The indirect pathway has an extra couple of connections in it, including disinhibition of the subthalamic nucleus. What is the end result on the thalamus, and therefore on movement initiated by the cerebral cortex?

Note:**Everyday Connections****The Myth of Left Brain/Right Brain**

There is a persistent myth that people are “right-brained” or “left-brained,” which is an oversimplification of an important concept about the cerebral hemispheres. There is some lateralization of function, in which the left side of the brain is devoted to language function and the right side is devoted to spatial and nonverbal reasoning. Whereas these functions are predominantly associated with those sides of the brain, there is no monopoly by either side on these functions. Many pervasive functions, such as language, are distributed globally around the cerebrum.

Some of the support for this misconception has come from studies of split brains. A drastic way to deal with a rare and devastating neurological condition (intractable epilepsy) is to separate the two hemispheres of the brain. After sectioning the corpus callosum, a split-brained patient will have trouble producing verbal responses on the basis of sensory information processed on the right side of the cerebrum, leading to the idea that the left side is responsible for language function.

However, there are well-documented cases of language functions lost from damage to the right side of the brain. The deficits seen in damage to the left side of the brain are classified as aphasia, a loss of speech function; damage on the right side can affect the use of language. Right-side damage can result in a loss of ability to understand figurative aspects of speech, such as jokes, irony, or metaphors. Nonverbal aspects of speech can be affected by damage to the right side, such as facial expression or body language, and right-side damage can lead to a “flat affect” in speech, or a loss of emotional expression in speech—sounding like a robot when talking.

The Diencephalon

The diencephalon is the one region of the adult brain that retains its name from embryologic development. The etymology of the word diencephalon translates to “through brain.” It is the connection between the cerebrum and the rest of the nervous system, with one exception. The rest of the brain, the

spinal cord, and the PNS all send information to the cerebrum through the diencephalon. Output from the cerebrum passes through the diencephalon. The single exception is the system associated with **olfaction**, or the sense of smell, which connects directly with the cerebrum. In the earliest vertebrate species, the cerebrum was not much more than olfactory bulbs that received peripheral information about the chemical environment (to call it smell in these organisms is imprecise because they lived in the ocean).

The diencephalon is deep beneath the cerebrum and constitutes the walls of the third ventricle. The diencephalon can be described as any region of the brain with “thalamus” in its name. The two major regions of the diencephalon are the thalamus itself and the hypothalamus ([\[link\]](#)). There are other structures, such as the **epithalamus**, which contains the pineal gland, or the **subthalamus**, which includes the subthalamic nucleus that is part of the basal nuclei.

Thalamus

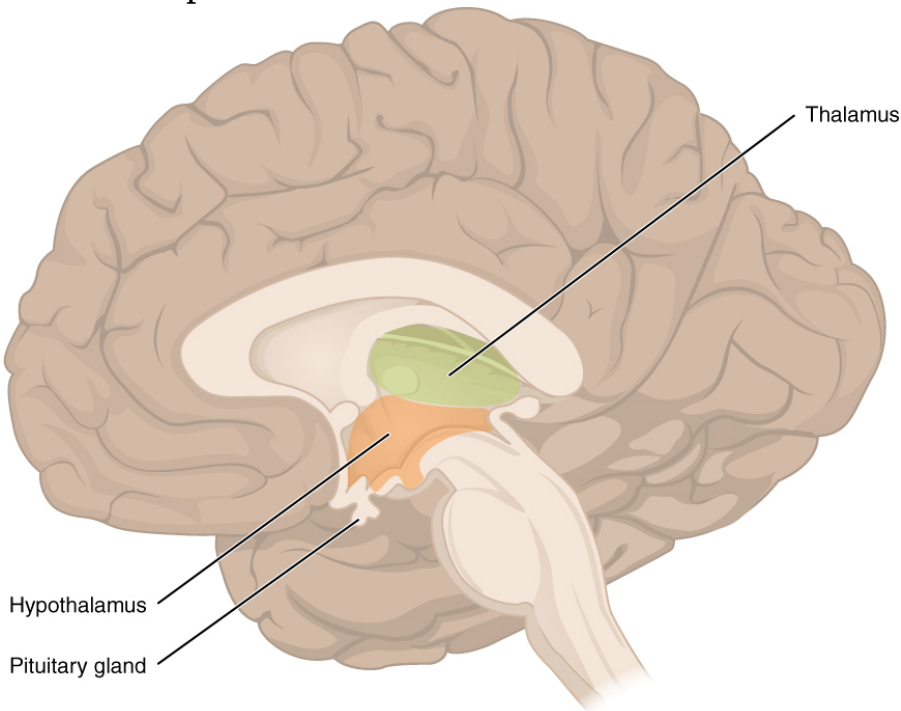
The **thalamus** is a collection of nuclei that relay information between the cerebral cortex and the periphery, spinal cord, or brain stem. All sensory information, except for the sense of smell, passes through the thalamus before processing by the cortex. Axons from the peripheral sensory organs, or intermediate nuclei, synapse in the thalamus, and thalamic neurons project directly to the cerebrum. It is a requisite synapse in any sensory pathway, except for olfaction. The thalamus does not just pass the information on, it also processes that information. For example, the portion of the thalamus that receives visual information will influence what visual stimuli are important, or what receives attention.

The cerebrum also sends information down to the thalamus, which usually communicates motor commands. This involves interactions with the cerebellum and other nuclei in the brain stem. The cerebrum interacts with the basal nuclei, which involves connections with the thalamus. The primary output of the basal nuclei is to the thalamus, which relays that output to the cerebral cortex. The cortex also sends information to the thalamus that will then influence the effects of the basal nuclei.

Hypothalamus

Inferior and slightly anterior to the thalamus is the **hypothalamus**, the other major region of the diencephalon. The hypothalamus is a collection of nuclei that are largely involved in regulating homeostasis. The hypothalamus is the executive region in charge of the autonomic nervous system and the endocrine system through its regulation of the anterior pituitary gland. Other parts of the hypothalamus are involved in memory and emotion as part of the limbic system.

The Diencephalon



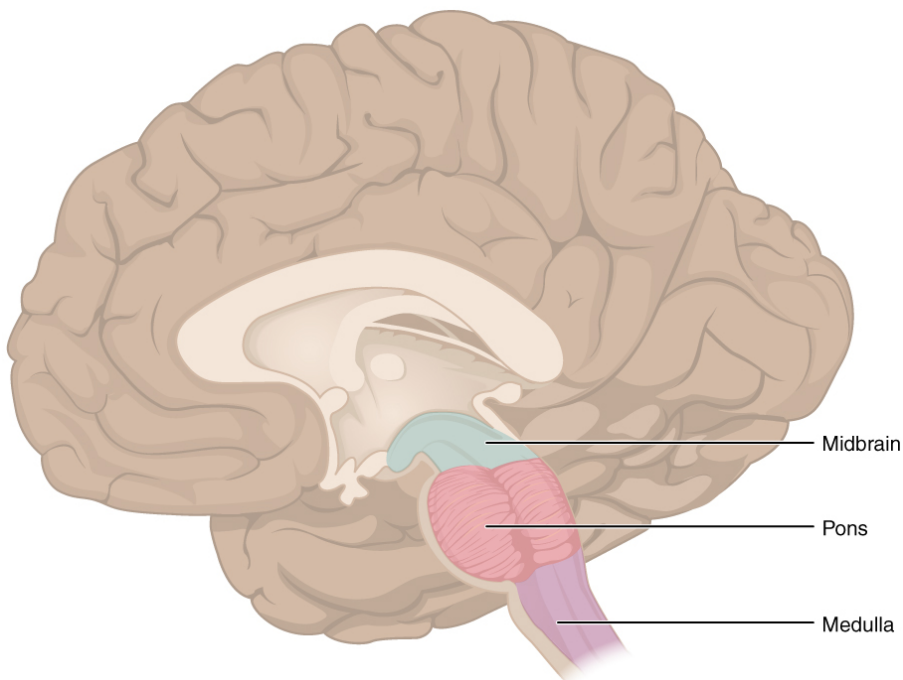
The diencephalon is composed primarily of the thalamus and hypothalamus, which together define the walls of the third ventricle. The thalami are two elongated, ovoid structures on either side of the midline that make contact in the middle. The hypothalamus is inferior and anterior to the thalamus, culminating in a sharp angle to which the pituitary gland is attached.

Brain Stem

The midbrain and hindbrain (composed of the pons and the medulla) are collectively referred to as the brain stem ([link](#)). The structure emerges from the ventral surface of the forebrain as a tapering cone that connects the brain to the spinal cord. Attached to the brain stem, but considered a separate region of the adult brain, is the cerebellum. The midbrain coordinates sensory representations of the visual, auditory, and somatosensory perceptual spaces. The pons is the main connection with the cerebellum. The pons and the medulla regulate several crucial functions, including the cardiovascular and respiratory systems and rates.

The cranial nerves connect through the brain stem and provide the brain with the sensory input and motor output associated with the head and neck, including most of the special senses. The major ascending and descending pathways between the spinal cord and brain, specifically the cerebrum, pass through the brain stem.

The Brain Stem



The brain stem comprises three regions: the midbrain, the pons, and the medulla.

Midbrain

One of the original regions of the embryonic brain, the midbrain is a small region between the thalamus and pons. It is separated into the **tectum** and **tegmentum**, from the Latin words for roof and floor, respectively. The cerebral aqueduct passes through the center of the midbrain, such that these regions are the roof and floor of that canal.

The tectum is composed of four bumps known as the colliculi (singular = colliculus), which means “little hill” in Latin. The **inferior colliculus** is the inferior pair of these enlargements and is part of the auditory brain stem pathway. Neurons of the inferior colliculus project to the thalamus, which then sends auditory information to the cerebrum for the conscious perception of sound. The **superior colliculus** is the superior pair and combines sensory information about visual space, auditory space, and somatosensory space. Activity in the superior colliculus is related to orienting the eyes to a sound or touch stimulus. If you are walking along the sidewalk on campus and you hear chirping, the superior colliculus coordinates that information with your awareness of the visual location of the tree right above you. That is the correlation of auditory and visual maps. If you suddenly feel something wet fall on your head, your superior colliculus integrates that with the auditory and visual maps and you know that the chirping bird just relieved itself on you. You want to look up to see the culprit, but do not.

The tegmentum is continuous with the gray matter of the rest of the brain stem. Throughout the midbrain, pons, and medulla, the tegmentum contains the nuclei that receive and send information through the cranial nerves, as well as regions that regulate important functions such as those of the cardiovascular and respiratory systems.

Pons

The word pons comes from the Latin word for bridge. It is visible on the anterior surface of the brain stem as the thick bundle of white matter attached to the cerebellum. The pons is the main connection between the cerebellum and the brain stem. The bridge-like white matter is only the anterior surface of the pons; the gray matter beneath that is a continuation of the tegmentum from the midbrain. Gray matter in the tegmentum region of the pons contains neurons receiving descending input from the forebrain that is sent to the cerebellum.

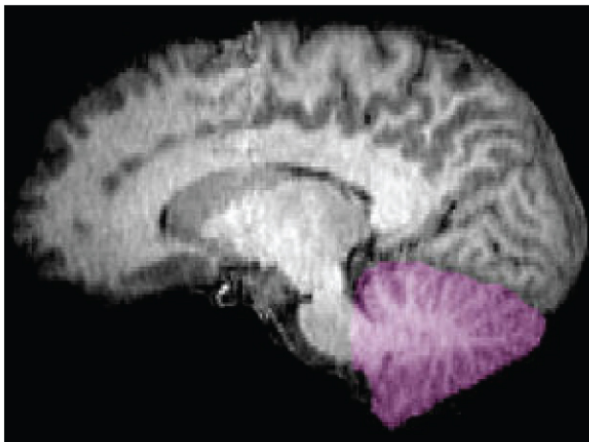
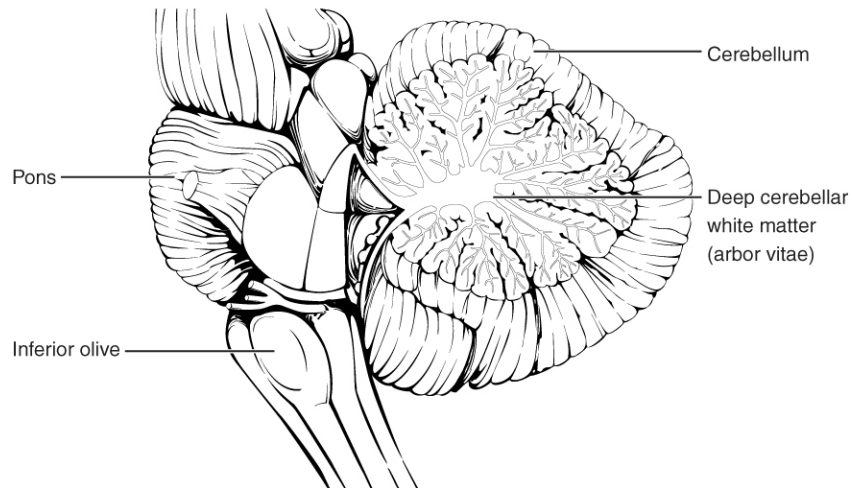
Medulla

The medulla is the region known as the myelencephalon in the embryonic brain. The initial portion of the name, “myel,” refers to the significant white matter found in this region—especially on its exterior, which is continuous with the white matter of the spinal cord. The tegmentum of the midbrain and pons continues into the medulla because this gray matter is responsible for processing cranial nerve information. A diffuse region of gray matter throughout the brain stem, known as the **reticular formation**, is related to sleep and wakefulness, such as general brain activity and attention.

The Cerebellum

The **cerebellum**, as the name suggests, is the “little brain.” It is covered in gyri and sulci like the cerebrum, and looks like a miniature version of that part of the brain ([\[link\]](#)). The cerebellum is largely responsible for comparing information from the cerebrum with sensory feedback from the periphery through the spinal cord. It accounts for approximately 10 percent of the mass of the brain.

The Cerebellum



The cerebellum is situated on the posterior surface of the brain stem. Descending input from the cerebellum enters through the large white matter structure of the pons. Ascending input from the periphery and spinal cord enters through the fibers of the inferior olive. Output goes to the midbrain, which sends a descending signal to the spinal cord.

Descending fibers from the cerebrum have branches that connect to neurons in the pons. Those neurons project into the cerebellum, providing a copy of

motor commands sent to the spinal cord. Sensory information from the periphery, which enters through spinal or cranial nerves, is copied to a nucleus in the medulla known as the **inferior olive**. Fibers from this nucleus enter the cerebellum and are compared with the descending commands from the cerebrum. If the primary motor cortex of the frontal lobe sends a command down to the spinal cord to initiate walking, a copy of that instruction is sent to the cerebellum. Sensory feedback from the muscles and joints, proprioceptive information about the movements of walking, and sensations of balance are sent to the cerebellum through the inferior olive and the cerebellum compares them. If walking is not coordinated, perhaps because the ground is uneven or a strong wind is blowing, then the cerebellum sends out a corrective command to compensate for the difference between the original cortical command and the sensory feedback. The output of the cerebellum is into the midbrain, which then sends a descending input to the spinal cord to correct the messages going to skeletal muscles.

The Spinal Cord

The description of the CNS is concentrated on the structures of the brain, but the spinal cord is another major organ of the system. Whereas the brain develops out of expansions of the neural tube into primary and then secondary vesicles, the spinal cord maintains the tube structure and is only specialized into certain regions. As the spinal cord continues to develop in the newborn, anatomical features mark its surface. The anterior midline is marked by the **anterior median fissure**, and the posterior midline is marked by the **posterior median sulcus**. Axons enter the posterior side through the **dorsal (posterior) nerve root**, which marks the **posterolateral sulcus** on either side. The axons emerging from the anterior side do so through the **ventral (anterior) nerve root**. Note that it is common to see the terms dorsal (dorsal = “back”) and ventral (ventral = “belly”) used interchangeably with posterior and anterior, particularly in reference to nerves and the structures of the spinal cord. You should learn to be comfortable with both.

On the whole, the posterior regions are responsible for sensory functions and the anterior regions are associated with motor functions. This comes

from the initial development of the spinal cord, which is divided into the **basal plate** and the **alar plate**. The basal plate is closest to the ventral midline of the neural tube, which will become the anterior face of the spinal cord and gives rise to motor neurons. The alar plate is on the dorsal side of the neural tube and gives rise to neurons that will receive sensory input from the periphery.

The length of the spinal cord is divided into regions that correspond to the regions of the vertebral column. The name of a spinal cord region corresponds to the level at which spinal nerves pass through the intervertebral foramina. Immediately adjacent to the brain stem is the cervical region, followed by the thoracic, then the lumbar, and finally the sacral region. The spinal cord is not the full length of the vertebral column because the spinal cord does not grow significantly longer after the first or second year, but the skeleton continues to grow. The nerves that emerge from the spinal cord pass through the intervertebral foramina at the respective levels. As the vertebral column grows, these nerves grow with it and result in a long bundle of nerves that resembles a horse's tail and is named the **cauda equina**. The sacral spinal cord is at the level of the upper lumbar vertebral bones. The spinal nerves extend from their various levels to the proper level of the vertebral column.

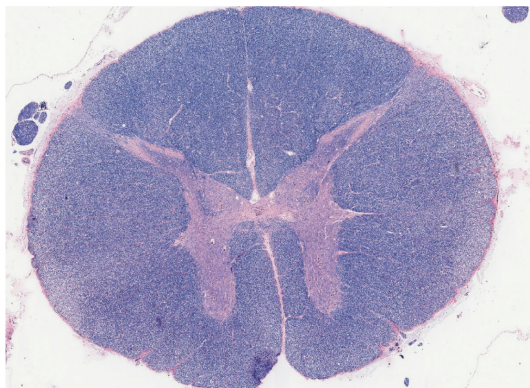
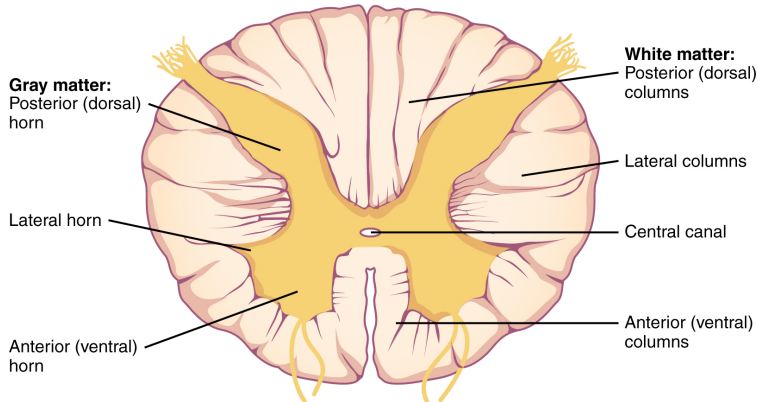
Gray Horns

In cross-section, the gray matter of the spinal cord has the appearance of an ink-blot test, with the spread of the gray matter on one side replicated on the other—a shape reminiscent of a bulbous capital “H.” As shown in [\[link\]](#), the gray matter is subdivided into regions that are referred to as horns. The **posterior horn** is responsible for sensory processing. The **anterior horn** sends out motor signals to the skeletal muscles. The **lateral horn**, which is only found in the thoracic, upper lumbar, and sacral regions, is the central component of the sympathetic division of the autonomic nervous system.

Some of the largest neurons of the spinal cord are the multipolar motor neurons in the anterior horn. The fibers that cause contraction of skeletal muscles are the axons of these neurons. The motor neuron that causes

contraction of the big toe, for example, is located in the sacral spinal cord. The axon that has to reach all the way to the belly of that muscle may be a meter in length. The neuronal cell body that maintains that long fiber must be quite large, possibly several hundred micrometers in diameter, making it one of the largest cells in the body.

Cross-section of Spinal Cord



The cross-section of a thoracic spinal cord segment shows the posterior, anterior, and lateral horns of gray matter, as well as the posterior, anterior, and lateral columns of white matter. LM $\times 40$. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)

White Columns

Just as the gray matter is separated into horns, the white matter of the spinal cord is separated into columns. **Ascending tracts** of nervous system fibers in these columns carry sensory information up to the brain, whereas **descending tracts** carry motor commands from the brain. Looking at the spinal cord longitudinally, the columns extend along its length as continuous bands of white matter. Between the two posterior horns of gray matter are the **posterior columns**. Between the two anterior horns, and bounded by the axons of motor neurons emerging from that gray matter area, are the **anterior columns**. The white matter on either side of the spinal cord, between the posterior horn and the axons of the anterior horn neurons, are the **lateral columns**. The posterior columns are composed of axons of ascending tracts. The anterior and lateral columns are composed of many different groups of axons of both ascending and descending tracts—the latter carrying motor commands down from the brain to the spinal cord to control output to the periphery.

Note:



Watch this [video](#) to learn about the gray matter of the spinal cord that receives input from fibers of the dorsal (posterior) root and sends information out through the fibers of the ventral (anterior) root. As discussed in this video, these connections represent the interactions of the CNS with peripheral structures for both sensory and motor functions. The cervical and lumbar spinal cords have enlargements as a result of larger populations of neurons. What are these enlargements responsible for?

Note:

Disorders of the...

Basal Nuclei

Parkinson's disease is a disorder of the basal nuclei, specifically of the substantia nigra, that demonstrates the effects of the direct and indirect pathways. Parkinson's disease is the result of neurons in the substantia nigra pars compacta dying. These neurons release dopamine into the striatum. Without that modulatory influence, the basal nuclei are stuck in the indirect pathway, without the direct pathway being activated. The direct pathway is responsible for increasing cortical movement commands. The increased activity of the indirect pathway results in the hypokinetic disorder of Parkinson's disease.

Parkinson's disease is neurodegenerative, meaning that neurons die that cannot be replaced, so there is no cure for the disorder. Treatments for Parkinson's disease are aimed at increasing dopamine levels in the striatum. Currently, the most common way of doing that is by providing the amino acid L-DOPA, which is a precursor to the neurotransmitter dopamine and can cross the blood-brain barrier. With levels of the precursor elevated, the remaining cells of the substantia nigra pars compacta can make more neurotransmitter and have a greater effect. Unfortunately, the patient will become less responsive to L-DOPA treatment as time progresses, and it can cause increased dopamine levels elsewhere in the brain, which are associated with psychosis or schizophrenia.

Note:

Visit this [site](#) for a thorough explanation of Parkinson's disease.

Note:

Compared with the nearest evolutionary relative, the chimpanzee, the human has a brain that is huge. At a point in the past, a common ancestor gave rise to the two species of humans and chimpanzees. That evolutionary history is long and is still an area of intense study. But something happened to increase the size of the human brain relative to the chimpanzee. Read [this article](#) in which the author explores the current understanding of why this happened.

According to one hypothesis about the expansion of brain size, what tissue might have been sacrificed so energy was available to grow our larger brain? Based on what you know about that tissue and nervous tissue, why would there be a trade-off between them in terms of energy use?

Chapter Review

The adult brain is separated into four major regions: the cerebrum, the diencephalon, the brain stem, and the cerebellum. The cerebrum is the largest portion and contains the cerebral cortex and subcortical nuclei. It is divided into two halves by the longitudinal fissure.

The cortex is separated into the frontal, parietal, temporal, and occipital lobes. The frontal lobe is responsible for motor functions, from planning movements through executing commands to be sent to the spinal cord and periphery. The most anterior portion of the frontal lobe is the prefrontal cortex, which is associated with aspects of personality through its influence on motor responses in decision-making.

The other lobes are responsible for sensory functions. The parietal lobe is where somatosensation is processed. The occipital lobe is where visual processing begins, although the other parts of the brain can contribute to visual function. The temporal lobe contains the cortical area for auditory processing, but also has regions crucial for memory formation.

Nuclei beneath the cerebral cortex, known as the subcortical nuclei, are responsible for augmenting cortical functions. The basal nuclei receive input from cortical areas and compare it with the general state of the individual through the activity of a dopamine-releasing nucleus. The output influences the activity of part of the thalamus that can then increase or decrease cortical activity that often results in changes to motor commands. The basal forebrain is responsible for modulating cortical activity in attention and memory. The limbic system includes deep cerebral nuclei that are responsible for emotion and memory.

The diencephalon includes the thalamus and the hypothalamus, along with some other structures. The thalamus is a relay between the cerebrum and the rest of the nervous system. The hypothalamus coordinates homeostatic functions through the autonomic and endocrine systems.

The brain stem is composed of the midbrain, pons, and medulla. It controls the head and neck region of the body through the cranial nerves. There are control centers in the brain stem that regulate the cardiovascular and respiratory systems.

The cerebellum is connected to the brain stem, primarily at the pons, where it receives a copy of the descending input from the cerebrum to the spinal cord. It can compare this with sensory feedback input through the medulla and send output through the midbrain that can correct motor commands for coordination.

Interactive Link Questions

Exercise:

Problem:

Watch this [video](#) to learn about the basal nuclei (also known as the basal ganglia), which have two pathways that process information within the cerebrum. As shown in this video, the direct pathway is the shorter pathway through the system that results in increased activity in the cerebral cortex and increased motor activity. The direct pathway is described as resulting in “disinhibition” of the thalamus. What does disinhibition mean? What are the two neurons doing individually to cause this?

Solution:

Both cells are inhibitory. The first cell inhibits the second one. Therefore, the second cell can no longer inhibit its target. This is disinhibition of that target across two synapses.

Exercise:**Problem:**

Watch this [video](#) to learn about the basal nuclei (also known as the basal ganglia), which have two pathways that process information within the cerebrum. As shown in this video, the indirect pathway is the longer pathway through the system that results in decreased activity in the cerebral cortex, and therefore less motor activity. The indirect pathway has an extra couple of connections in it, including disinhibition of the subthalamic nucleus. What is the end result on the thalamus, and therefore on movement initiated by the cerebral cortex?

Solution:

By disinhibiting the subthalamic nucleus, the indirect pathway increases excitation of the globus pallidus internal segment. That, in turn, inhibits the thalamus, which is the opposite effect of the direct pathway that disinhibits the thalamus.

Exercise:

Problem:

Watch this [video](#) to learn about the gray matter of the spinal cord that receives input from fibers of the dorsal (posterior) root and sends information out through the fibers of the ventral (anterior) root. As discussed in this video, these connections represent the interactions of the CNS with peripheral structures for both sensory and motor functions. The cervical and lumbar spinal cords have enlargements as a result of larger populations of neurons. What are these enlargements responsible for?

Solution:

There are more motor neurons in the anterior horns that are responsible for movement in the limbs. The cervical enlargement is for the arms, and the lumbar enlargement is for the legs.

Exercise:**Problem:**

Compared with the nearest evolutionary relative, the chimpanzee, the human has a brain that is huge. At a point in the past, a common ancestor gave rise to the two species of humans and chimpanzees. That evolutionary history is long and is still an area of intense study. But something happened to increase the size of the human brain relative to the chimpanzee. Read this [article](#) in which the author explores the current understanding of why this happened.

According to one hypothesis about the expansion of brain size, what tissue might have been sacrificed so energy was available to grow our larger brain? Based on what you know about that tissue and nervous tissue, why would there be a trade-off between them in terms of energy use?

Solution:

Energy is needed for the brain to develop and perform higher cognitive functions. That energy is not available for the muscle tissues to develop and function. The hypothesis suggests that humans have larger brains and less muscle mass, and chimpanzees have the smaller brains but more muscle mass.

Review Questions

Exercise:

Problem:

Which lobe of the cerebral cortex is responsible for generating motor commands?

- a. temporal
- b. parietal
- c. occipital
- d. frontal

Solution:

D

Exercise:

Problem: What region of the diencephalon coordinates homeostasis?

- a. thalamus
- b. epithalamus
- c. hypothalamus
- d. subthalamus

Solution:

C

Exercise:

Problem:

What level of the brain stem is the major input to the cerebellum?

- a. midbrain
- b. pons
- c. medulla
- d. spinal cord

Solution:

B

Exercise:

Problem:

What region of the spinal cord contains motor neurons that direct the movement of skeletal muscles?

- a. anterior horn
- b. posterior horn
- c. lateral horn
- d. alar plate

Solution:

A

Exercise:

Problem:

Brodmann's areas map different regions of the _____ to particular functions.

- a. cerebellum

- b. cerebral cortex
- c. basal forebrain
- d. corpus callosum

Solution:

B

Critical Thinking Questions

Exercise:

Problem:

Damage to specific regions of the cerebral cortex, such as through a stroke, can result in specific losses of function. What functions would likely be lost by a stroke in the temporal lobe?

Solution:

The temporal lobe has sensory functions associated with hearing and vision, as well as being important for memory. A stroke in the temporal lobe can result in specific sensory deficits in these systems (known as agnosias) or losses in memory.

Exercise:

Problem:

Why do the anatomical inputs to the cerebellum suggest that it can compare motor commands and sensory feedback?

Solution:

A copy of descending input from the cerebrum to the spinal cord, through the pons, and sensory feedback from the spinal cord and special senses like balance, through the medulla, both go to the

cerebellum. It can therefore send output through the midbrain that will correct spinal cord control of skeletal muscle movements.

Glossary

alar plate

developmental region of the spinal cord that gives rise to the posterior horn of the gray matter

amygdala

nucleus deep in the temporal lobe of the cerebrum that is related to memory and emotional behavior

anterior column

white matter between the anterior horns of the spinal cord composed of many different groups of axons of both ascending and descending tracts

anterior horn

gray matter of the spinal cord containing multipolar motor neurons, sometimes referred to as the ventral horn

anterior median fissure

deep midline feature of the anterior spinal cord, marking the separation between the right and left sides of the cord

ascending tract

central nervous system fibers carrying sensory information from the spinal cord or periphery to the brain

basal forebrain

nuclei of the cerebrum related to modulation of sensory stimuli and attention through broad projections to the cerebral cortex, loss of which is related to Alzheimer's disease

basal nuclei

nuclei of the cerebrum (with a few components in the upper brain stem and diencephalon) that are responsible for assessing cortical movement commands and comparing them with the general state of the individual through broad modulatory activity of dopamine neurons; largely related to motor functions, as evidenced through the symptoms of Parkinson's and Huntington's diseases

basal plate

developmental region of the spinal cord that gives rise to the lateral and anterior horns of gray matter

Broca's area

region of the frontal lobe associated with the motor commands necessary for speech production and located only in the cerebral hemisphere responsible for language production, which is the left side in approximately 95 percent of the population

Brodmann's areas

mapping of regions of the cerebral cortex based on microscopic anatomy that relates specific areas to functional differences, as described by Brodmann in the early 1900s

cauda equina

bundle of spinal nerve roots that descend from the lower spinal cord below the first lumbar vertebra and lie within the vertebral cavity; has the appearance of a horse's tail

caudate

nucleus deep in the cerebrum that is part of the basal nuclei; along with the putamen, it is part of the striatum

central sulcus

surface landmark of the cerebral cortex that marks the boundary between the frontal and parietal lobes

cerebral cortex

outer gray matter covering the forebrain, marked by wrinkles and folds known as gyri and sulci

cerebrum

region of the adult brain that develops from the telencephalon and is responsible for higher neurological functions such as memory, emotion, and consciousness

cerebellum

region of the adult brain connected primarily to the pons that developed from the metencephalon (along with the pons) and is largely responsible for comparing information from the cerebrum with sensory feedback from the periphery through the spinal cord

cerebral hemisphere

one half of the bilaterally symmetrical cerebrum

corpus callosum

large white matter structure that connects the right and left cerebral hemispheres

descending tract

central nervous system fibers carrying motor commands from the brain to the spinal cord or periphery

direct pathway

connections within the basal nuclei from the striatum to the globus pallidus internal segment and substantia nigra pars reticulata that disinhibit the thalamus to increase cortical control of movement

disinhibition

disynaptic connection in which the first synapse inhibits the second cell, which then stops inhibiting the final target

dorsal (posterior) nerve root

axons entering the posterior horn of the spinal cord

epithalamus

region of the diencephalon containing the pineal gland

frontal eye field

region of the frontal lobe associated with motor commands to orient the eyes toward an object of visual attention

frontal lobe

region of the cerebral cortex directly beneath the frontal bone of the cranium

globus pallidus

nuclei deep in the cerebrum that are part of the basal nuclei and can be divided into the internal and external segments

gyrus

ridge formed by convolutions on the surface of the cerebrum or cerebellum

hippocampus

gray matter deep in the temporal lobe that is very important for long-term memory formation

hypothalamus

major region of the diencephalon that is responsible for coordinating autonomic and endocrine control of homeostasis

indirect pathway

connections within the basal nuclei from the striatum through the globus pallidus external segment and subthalamic nucleus to the globus pallidus internal segment/substantia nigra pars compacta that result in inhibition of the thalamus to decrease cortical control of movement

inferior colliculus

half of the midbrain tectum that is part of the brain stem auditory pathway

inferior olive

nucleus in the medulla that is involved in processing information related to motor control

kinesthesia

general sensory perception of movement of the body

lateral column

white matter of the spinal cord between the posterior horn on one side and the axons from the anterior horn on the same side; composed of many different groups of axons, of both ascending and descending tracts, carrying motor commands to and from the brain

lateral horn

region of the spinal cord gray matter in the thoracic, upper lumbar, and sacral regions that is the central component of the sympathetic division of the autonomic nervous system

lateral sulcus

surface landmark of the cerebral cortex that marks the boundary between the temporal lobe and the frontal and parietal lobes

limbic cortex

collection of structures of the cerebral cortex that are involved in emotion, memory, and behavior and are part of the larger limbic system

limbic system

structures at the edge (limit) of the boundary between the forebrain and hindbrain that are most associated with emotional behavior and memory formation

longitudinal fissure

large separation along the midline between the two cerebral hemispheres

occipital lobe

region of the cerebral cortex directly beneath the occipital bone of the cranium

olfaction

special sense responsible for smell, which has a unique, direct connection to the cerebrum

parietal lobe

region of the cerebral cortex directly beneath the parietal bone of the cranium

parieto-occipital sulcus

groove in the cerebral cortex representing the border between the parietal and occipital cortices

postcentral gyrus

primary motor cortex located in the frontal lobe of the cerebral cortex

posterior columns

white matter of the spinal cord that lies between the posterior horns of the gray matter, sometimes referred to as the dorsal column; composed of axons of ascending tracts that carry sensory information up to the brain

posterior horn

gray matter region of the spinal cord in which sensory input arrives, sometimes referred to as the dorsal horn

posterior median sulcus

midline feature of the posterior spinal cord, marking the separation between right and left sides of the cord

posterolateral sulcus

feature of the posterior spinal cord marking the entry of posterior nerve roots and the separation between the posterior and lateral columns of the white matter

precentral gyrus

ridge just posterior to the central sulcus, in the parietal lobe, where somatosensory processing initially takes place in the cerebrum

prefrontal lobe

specific region of the frontal lobe anterior to the more specific motor function areas, which can be related to the early planning of movements and intentions to the point of being personality-type functions

premotor area

region of the frontal lobe responsible for planning movements that will be executed through the primary motor cortex

proprioception

general sensory perceptions providing information about location and movement of body parts; the “sense of the self”

putamen

nucleus deep in the cerebrum that is part of the basal nuclei; along with the caudate, it is part of the striatum

reticular formation

diffuse region of gray matter throughout the brain stem that regulates sleep, wakefulness, and states of consciousness

somatosensation

general senses related to the body, usually thought of as the senses of touch, which would include pain, temperature, and proprioception

striatum

the caudate and putamen collectively, as part of the basal nuclei, which receive input from the cerebral cortex

subcortical nucleus

all the nuclei beneath the cerebral cortex, including the basal nuclei and the basal forebrain

substantia nigra pars compacta

nuclei within the basal nuclei that release dopamine to modulate the function of the striatum; part of the motor pathway

substantia nigra pars reticulata

nuclei within the basal nuclei that serve as an output center of the nuclei; part of the motor pathway

subthalamus

nucleus within the basal nuclei that is part of the indirect pathway

sulcus

groove formed by convolutions in the surface of the cerebral cortex

superior colliculus

half of the midbrain tectum that is responsible for aligning visual, auditory, and somatosensory spatial perceptions

tectum

region of the midbrain, thought of as the roof of the cerebral aqueduct, which is subdivided into the inferior and superior colliculi

tegmentum

region of the midbrain, thought of as the floor of the cerebral aqueduct, which continues into the pons and medulla as the floor of the fourth ventricle

temporal lobe

region of the cerebral cortex directly beneath the temporal bone of the cranium

thalamus

major region of the diencephalon that is responsible for relaying information between the cerebrum and the hindbrain, spinal cord, and periphery

ventral (anterior) nerve root

axons emerging from the anterior or lateral horns of the spinal cord

Circulation and the Central Nervous System

By the end of this section, you will be able to:

- Describe the vessels that supply the CNS with blood
- Name the components of the ventricular system and the regions of the brain in which each is located
- Explain the production of cerebrospinal fluid and its flow through the ventricles
- Explain how a disruption in circulation would result in a stroke

The CNS is crucial to the operation of the body, and any compromise in the brain and spinal cord can lead to severe difficulties. The CNS has a privileged blood supply, as suggested by the blood-brain barrier. The function of the tissue in the CNS is crucial to the survival of the organism, so the contents of the blood cannot simply pass into the central nervous tissue. To protect this region from the toxins and pathogens that may be traveling through the blood stream, there is strict control over what can move out of the general systems and into the brain and spinal cord. Because of this privilege, the CNS needs specialized structures for the maintenance of circulation. This begins with a unique arrangement of blood vessels carrying fresh blood into the CNS. Beyond the supply of blood, the CNS filters that blood into cerebrospinal fluid (CSF), which is then circulated through the cavities of the brain and spinal cord called ventricles.

Blood Supply to the Brain

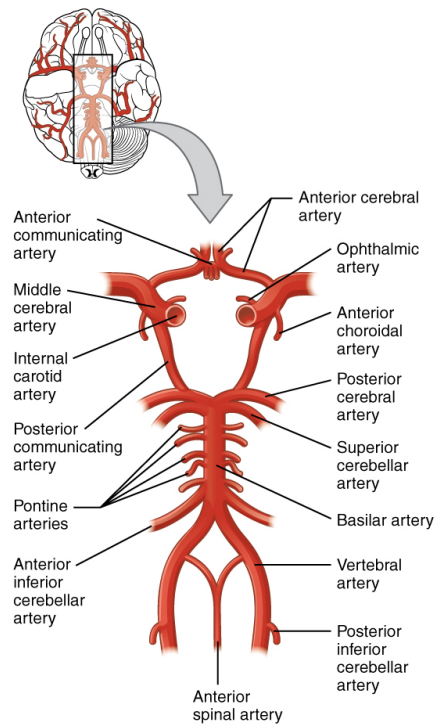
A lack of oxygen to the CNS can be devastating, and the cardiovascular system has specific regulatory reflexes to ensure that the blood supply is not interrupted. There are multiple routes for blood to get into the CNS, with specializations to protect that blood supply and to maximize the ability of the brain to get an uninterrupted perfusion.

Arterial Supply

The major artery carrying recently oxygenated blood away from the heart is the aorta. The very first branches off the aorta supply the heart with nutrients and oxygen. The next branches give rise to the **common carotid arteries**, which further branch into the **internal carotid arteries**. The external carotid arteries supply blood to the tissues on the surface of the cranium. The bases of the common carotids contain stretch receptors that immediately respond to the drop in blood pressure upon standing. The **orthostatic reflex** is a reaction to this change in body position, so that blood pressure is maintained against the increasing effect of gravity (orthostatic means “standing up”). Heart rate increases—a reflex of the sympathetic division of the autonomic nervous system—and this raises blood pressure.

The internal carotid artery enters the cranium through the **carotid canal** in the temporal bone. A second set of vessels that supply the CNS are the **vertebral arteries**, which are protected as they pass through the neck region by the transverse foramina of the cervical vertebrae. The vertebral arteries enter the cranium through the **foramen magnum** of the occipital bone. Branches off the left and right vertebral arteries merge into the **anterior spinal artery** supplying the anterior aspect of the spinal cord, found along the anterior median fissure. The two vertebral arteries then merge into the **basilar artery**, which gives rise to branches to the brain stem and cerebellum. The left and right internal carotid arteries and branches of the basilar artery all become the **circle of Willis**, a confluence of arteries that can maintain perfusion of the brain even if narrowing or a blockage limits flow through one part ([link](#)).

Circle of Willis



The blood supply to the brain enters through the internal carotid arteries and the vertebral arteries, eventually giving rise to the circle of Willis.

Note:



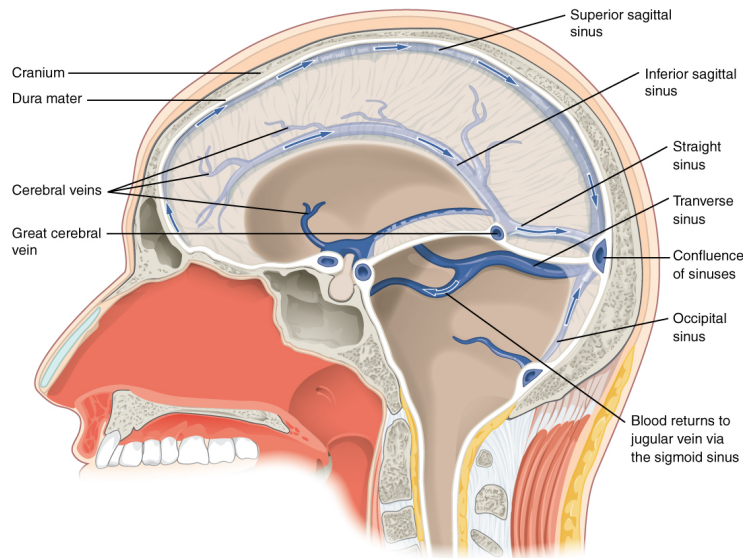
Watch this [animation](#) to see how blood flows to the brain and passes through the circle of Willis before being distributed through the cerebrum. The circle of Willis is a specialized arrangement of arteries that ensure constant perfusion of the cerebrum even in the event of a blockage of one of the arteries in the circle. The animation shows the normal direction of flow through the circle of Willis to the middle cerebral artery. Where would the blood come from if there were a blockage just posterior to the middle cerebral artery on the left?

Venous Return

After passing through the CNS, blood returns to the circulation through a series of **dural sinuses** and veins ([link](#)). The **superior sagittal sinus** runs in the groove of the longitudinal fissure, where it absorbs CSF from the meninges. The superior sagittal sinus drains to the confluence of sinuses, along with the **occipital sinuses** and **straight sinus**, to then drain into the **transverse sinuses**. The transverse sinuses connect to the **sigmoid sinuses**,

which then connect to the **jugular veins**. From there, the blood continues toward the heart to be pumped to the lungs for reoxygenation.

Dural Sinuses and Veins

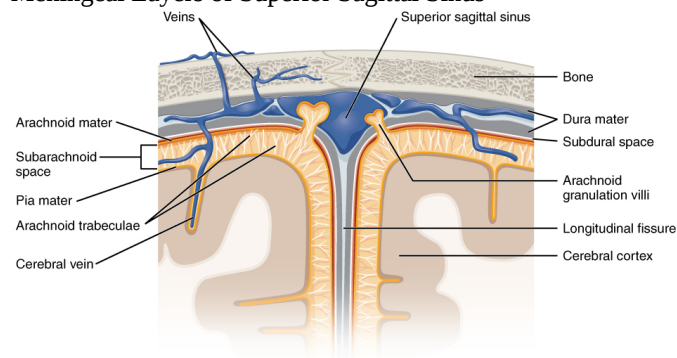


Blood drains from the brain through a series of sinuses that connect to the jugular veins.

Protective Coverings of the Brain and Spinal Cord

The outer surface of the CNS is covered by a series of membranes composed of connective tissue called the **meninges**, which protect the brain. The **dura mater** is a thick fibrous layer and a strong protective sheath over the entire brain and spinal cord. It is anchored to the inner surface of the cranium and vertebral cavity. The **arachnoid mater** is a membrane of thin fibrous tissue that forms a loose sac around the CNS. Beneath the arachnoid is a thin, filamentous mesh called the **arachnoid trabeculae**, which looks like a spider web, giving this layer its name. Directly adjacent to the surface of the CNS is the **pia mater**, a thin fibrous membrane that follows the convolutions of gyri and sulci in the cerebral cortex and fits into other grooves and indentations ([\[link\]](#)).

Meningeal Layers of Superior Sagittal Sinus



The layers of the meninges in the longitudinal fissure of the superior sagittal sinus are shown, with the dura mater adjacent to the inner surface of the cranium, the pia mater adjacent to the surface of the brain, and the arachnoid and subarachnoid space between them. An

arachnoid villus is shown emerging into the dural sinus to allow CSF to filter back into the blood for drainage.

Dura Mater

Like a thick cap covering the brain, the dura mater is a tough outer covering. The name comes from the Latin for “tough mother” to represent its physically protective role. It encloses the entire CNS and the major blood vessels that enter the cranium and vertebral cavity. It is directly attached to the inner surface of the bones of the cranium and to the very end of the vertebral cavity.

There are infoldings of the dura that fit into large crevasses of the brain. Two infoldings go through the midline separations of the cerebrum and cerebellum; one forms a shelf-like tent between the occipital lobes of the cerebrum and the cerebellum, and the other surrounds the pituitary gland. The dura also surrounds and supports the venous sinuses.

Arachnoid Mater

The middle layer of the meninges is the arachnoid, named for the spider-web-like trabeculae between it and the pia mater. The arachnoid defines a sac-like enclosure around the CNS. The trabeculae are found in the **subarachnoid space**, which is filled with circulating CSF. The arachnoid emerges into the dural sinuses as the **arachnoid granulations**, where the CSF is filtered back into the blood for drainage from the nervous system.

The subarachnoid space is filled with circulating CSF, which also provides a liquid cushion to the brain and spinal cord. Similar to clinical blood work, a sample of CSF can be withdrawn to find chemical evidence of neuropathology or metabolic traces of the biochemical functions of nervous tissue.

Pia Mater

The outer surface of the CNS is covered in the thin fibrous membrane of the pia mater. It is thought to have a continuous layer of cells providing a fluid-impermeable membrane. The name pia mater comes from the Latin for “tender mother,” suggesting the thin membrane is a gentle covering for the brain. The pia extends into every convolution of the CNS, lining the inside of the sulci in the cerebral and cerebellar cortices. At the end of the spinal cord, a thin filament extends from the inferior end of CNS at the upper lumbar region of the vertebral column to the sacral end of the vertebral column. Because the spinal cord does not extend through the lower lumbar region of the vertebral column, a needle can be inserted through the dura and arachnoid layers to withdraw CSF. This procedure is called a **lumbar puncture** and avoids the risk of damaging the central tissue of the spinal cord. Blood vessels that are nourishing the central nervous tissue are between the pia mater and the nervous tissue.

Note:

Disorders of the...

Meninges

Meningitis is an inflammation of the meninges, the three layers of fibrous membrane that surround the CNS. Meningitis can be caused by infection by bacteria or viruses. The particular pathogens are not special to meningitis; it is just an inflammation of that specific set of tissues from what might be a broader infection. Bacterial meningitis can be caused by *Streptococcus*, *Staphylococcus*, or the tuberculosis pathogen, among many others. Viral meningitis is usually the result of common enteroviruses (such as those that cause intestinal disorders), but may be the result of the herpes virus or West Nile virus. Bacterial meningitis tends to be more severe.

The symptoms associated with meningitis can be fever, chills, nausea, vomiting, light sensitivity, soreness of the neck, or severe headache. More important are the neurological symptoms, such as changes in mental state (confusion, memory deficits, and other dementia-type symptoms). A serious risk of meningitis can be damage to peripheral structures because of the nerves that pass through the meninges. Hearing loss is a common result of meningitis.

The primary test for meningitis is a lumbar puncture. A needle inserted into the lumbar region of the spinal column through the dura mater and arachnoid membrane into the subarachnoid space can be used to withdraw the fluid for chemical testing. Fatality occurs in 5 to 40 percent of children and 20 to 50 percent of adults with bacterial meningitis. Treatment of bacterial meningitis is through antibiotics, but viral meningitis cannot be treated with antibiotics because viruses do not respond to that type of drug. Fortunately, the viral forms are milder.

Note:



Watch this [video](#) that describes the procedure known as the lumbar puncture, a medical procedure used to sample the CSF. Because of the anatomy of the CNS, it is a relative safe location to insert a needle. Why is the lumbar puncture performed in the lower lumbar area of the vertebral column?

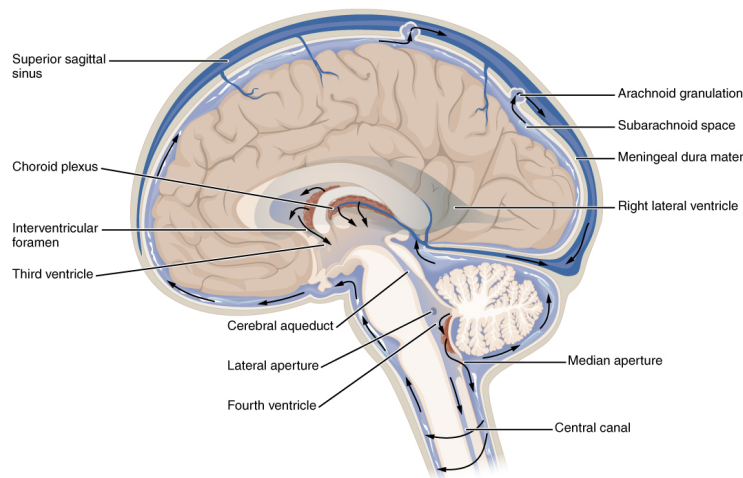
The Ventricular System

Cerebrospinal fluid (CSF) circulates throughout and around the CNS. In other tissues, water and small molecules are filtered through capillaries as the major contributor to the interstitial fluid. In the brain, CSF is produced in special structures to perfuse through the nervous tissue of the CNS and is continuous with the interstitial fluid. Specifically, CSF circulates to remove metabolic wastes from the interstitial fluids of nervous tissues and return them to the blood stream. The **ventricles** are the open spaces within the brain where CSF circulates. In some of these spaces, CSF is produced by filtering of the blood that is performed by a specialized membrane known as a choroid plexus. The CSF circulates through all of the ventricles to eventually emerge into the subarachnoid space where it will be reabsorbed into the blood.

The Ventricles

There are four ventricles within the brain, all of which developed from the original hollow space within the neural tube, the **central canal**. The first two are named the **lateral ventricles** and are deep within the cerebrum. These ventricles are connected to the **third ventricle** by two openings called the **interventricular foramina**. The third ventricle is the space between the left and right sides of the diencephalon, which opens into the **cerebral aqueduct** that passes through the midbrain. The aqueduct opens into the **fourth ventricle**, which is the space between the cerebellum and the pons and upper medulla ([link](#)).

Cerebrospinal Fluid Circulation



The choroid plexus in the four ventricles produce CSF, which is circulated through the ventricular system and then enters the subarachnoid space through the median and lateral apertures.

The CSF is then reabsorbed into the blood at the arachnoid granulations, where the arachnoid membrane emerges into the dural sinuses.

As the telencephalon enlarges and grows into the cranial cavity, it is limited by the space within the skull. The telencephalon is the most anterior region of what was the neural tube, but cannot grow past the limit of the frontal bone of the skull. Because the cerebrum fits into this space, it takes on a C-shaped formation, through the frontal, parietal, occipital, and finally temporal regions. The space within the telencephalon is stretched into this same C-shape. The two ventricles are in the left and right sides, and were at one time referred to as the first and second ventricles. The interventricular foramina connect the frontal region of the lateral ventricles with the third ventricle.

The third ventricle is the space bounded by the medial walls of the hypothalamus and thalamus. The two thalami touch in the center in most brains as the massa intermedia, which is surrounded by the third ventricle. The cerebral aqueduct opens just inferior to the epithalamus and passes through the midbrain. The tectum and tegmentum of the midbrain are the roof and floor of the cerebral aqueduct, respectively. The aqueduct opens up into the fourth ventricle. The floor of the fourth ventricle is the dorsal surface of the pons and upper medulla (that gray matter making a continuation of the tegmentum of the midbrain). The fourth ventricle then narrows into the central canal of the spinal cord.

The ventricular system opens up to the subarachnoid space from the fourth ventricle. The single **median aperture** and the pair of **lateral apertures** connect to the subarachnoid space so that CSF can flow through the ventricles and around the outside of the CNS. Cerebrospinal fluid is produced within the ventricles by a type of specialized membrane called a **choroid plexus**. Ependymal cells (one of the types of glial cells described in the introduction to the nervous system) surround blood capillaries and filter the blood to make CSF. The fluid is a clear solution with a limited amount of the constituents of blood. It is essentially water, small molecules, and electrolytes. Oxygen and carbon dioxide are dissolved into the CSF, as they are in blood, and can diffuse between the fluid and the nervous tissue.

Cerebrospinal Fluid Circulation


The choroid plexuses are found in all four ventricles. Observed in dissection, they appear as soft, fuzzy structures that may still be pink, depending on how well the circulatory system is cleared in preparation of the tissue. The

CSF is produced from components extracted from the blood, so its flow out of the ventricles is tied to the pulse of cardiovascular circulation.

From the lateral ventricles, the CSF flows into the third ventricle, where more CSF is produced, and then through the cerebral aqueduct into the fourth ventricle where even more CSF is produced. A very small amount of CSF is filtered at any one of the plexuses, for a total of about 500 milliliters daily, but it is continuously made and pulses through the ventricular system, keeping the fluid moving. From the fourth ventricle, CSF can continue down the central canal of the spinal cord, but this is essentially a cul-de-sac, so more of the fluid leaves the ventricular system and moves into the subarachnoid space through the median and lateral apertures.

Within the subarachnoid space, the CSF flows around all of the CNS, providing two important functions. As with elsewhere in its circulation, the CSF picks up metabolic wastes from the nervous tissue and moves it out of the CNS. It also acts as a liquid cushion for the brain and spinal cord. By surrounding the entire system in the subarachnoid space, it provides a thin buffer around the organs within the strong, protective dura mater. The arachnoid granulations are outpocketings of the arachnoid membrane into the dural sinuses so that CSF can be reabsorbed into the blood, along with the metabolic wastes. From the dural sinuses, blood drains out of the head and neck through the jugular veins, along with the rest of the circulation for blood, to be reoxygenated by the lungs and wastes to be filtered out by the kidneys ([link](#)).

Note:



Watch this [animation](#) that shows the flow of CSF through the brain and spinal cord, and how it originates from the ventricles and then spreads into the space within the meninges, where the fluids then move into the venous sinuses to return to the cardiovascular circulation. What are the structures that produce CSF and where are they found? How are the structures indicated in this animation?

Components of CSF Circulation						
	Lateral ventricles	Third ventricle	Cerebral aqueduct	Fourth ventricle	Central canal	Subarachnoid space
Location in CNS	Cerebrum	Diencephalon	Midbrain	Between pons/upper medulla and cerebellum	Spinal cord	External to entire CNS
Blood vessel structure	Choroid plexus	Choroid plexus	None	Choroid plexus	None	Arachnoid granulations

Note:**Disorders of the...****Central Nervous System**

The supply of blood to the brain is crucial to its ability to perform many functions. Without a steady supply of oxygen, and to a lesser extent glucose, the nervous tissue in the brain cannot keep up its extensive electrical activity. These nutrients get into the brain through the blood, and if blood flow is interrupted, neurological function is compromised.

The common name for a disruption of blood supply to the brain is a stroke. It is caused by a blockage to an artery in the brain. The blockage is from some type of embolus: a blood clot, a fat embolus, or an air bubble. When the blood cannot travel through the artery, the surrounding tissue that is deprived starves and dies. Strokes will often result in the loss of very specific functions. A stroke in the lateral medulla, for example, can cause a loss in the ability to swallow. Sometimes, seemingly unrelated functions will be lost because they are dependent on structures in the same region. Along with the swallowing in the previous example, a stroke in that region could affect sensory functions from the face or extremities because important white matter pathways also pass through the lateral medulla. Loss of blood flow to specific regions of the cortex can lead to the loss of specific higher functions, from the ability to recognize faces to the ability to move a particular region of the body. Severe or limited memory loss can be the result of a temporal lobe stroke.

Related to strokes are transient ischemic attacks (TIAs), which can also be called “mini-strokes.” These are events in which a physical blockage may be temporary, cutting off the blood supply and oxygen to a region, but not to the extent that it causes cell death in that region. While the neurons in that area are recovering from the event, neurological function may be lost. Function can return if the area is able to recover from the event.

Recovery from a stroke (or TIA) is strongly dependent on the speed of treatment. Often, the person who is present and notices something is wrong must then make a decision. The mnemonic **FAST** helps people remember what to look for when someone is dealing with sudden losses of neurological function. If someone complains of feeling “funny,” check these things quickly: Look at the person’s face. Does he or she have problems moving **F**ace muscles and making regular facial expressions? Ask the person to raise his or her **A**rms above the head. Can the person lift one arm but not the other? Has the person’s **S**peech changed? Is he or she slurring words or having trouble saying things? If any of these things have happened, then it is **T**ime to call for help.

Sometimes, treatment with blood-thinning drugs can alleviate the problem, and recovery is possible. If the tissue is damaged, the amazing thing about the nervous system is that it is adaptable. With physical, occupational, and speech therapy, victims of strokes can recover, or more accurately relearn, functions.

Chapter Review

The CNS has a privileged blood supply established by the blood-brain barrier. Establishing this barrier are anatomical structures that help to protect and isolate the CNS. The arterial blood to the brain comes from the internal carotid and vertebral arteries, which both contribute to the unique circle of Willis that provides constant perfusion of the brain even if one of the blood vessels is blocked or narrowed. That blood is eventually filtered to make a separate medium, the CSF, that circulates within the spaces of the brain and then into the surrounding space defined by the meninges, the protective covering of the brain and spinal cord.

The blood that nourishes the brain and spinal cord is behind the glial-cell–enforced blood-brain barrier, which limits the exchange of material from blood vessels with the interstitial fluid of the nervous tissue. Thus, metabolic wastes are collected in cerebrospinal fluid that circulates through the CNS. This fluid is produced by filtering blood at the choroid plexuses in the four ventricles of the brain. It then circulates through the ventricles and into the subarachnoid space, between the pia mater and the arachnoid mater. From the arachnoid granulations, CSF is reabsorbed into the blood, removing the waste from the privileged central nervous tissue.

The blood, now with the reabsorbed CSF, drains out of the cranium through the dural sinuses. The dura mater is the tough outer covering of the CNS, which is anchored to the inner surface of the cranial and vertebral cavities. It surrounds the venous space known as the dural sinuses, which connect to the jugular veins, where blood drains from the head and neck.

Interactive Link Questions

Exercise:**Problem:**

Watch this [animation](#) to see how blood flows to the brain and passes through the circle of Willis before being distributed through the cerebrum. The circle of Willis is a specialized arrangement of arteries that ensure constant perfusion of the cerebrum even in the event of a blockage of one of the arteries in the circle. The animation shows the normal direction of flow through the circle of Willis to the middle cerebral artery. Where would the blood come from if there were a blockage just posterior to the middle cerebral artery on the left?

Solution:

If blood could not get to the middle cerebral artery through the posterior circulation, the blood would flow around the circle of Willis to reach that artery from an anterior vessel. Blood flow would just reverse within the circle.

Exercise:**Problem:**

Watch this [video](#) that describes the procedure known as the lumbar puncture, a medical procedure used to sample the CSF. Because of the anatomy of the CNS, it is a relative safe location to insert a needle. Why is the lumbar puncture performed in the lower lumbar area of the vertebral column?

Solution:

The spinal cord ends in the upper lumbar area of the vertebral column, so a needle inserted lower than that will not damage the nervous tissue of the CNS.

Exercise:**Problem:**

Watch this [animation](#) that shows the flow of CSF through the brain and spinal cord, and how it originates from the ventricles and then spreads into the space within the meninges, where the fluids then move into the venous sinuses to return to the cardiovascular circulation. What are the structures that produce CSF and where are they found? How are the structures indicated in this animation?

Solution:

The choroid plexuses of the ventricles make CSF. As shown, there is a little of the blue color appearing in each ventricle that is joined by the color flowing from the other ventricles.

Review Questions**Exercise:**

Problem: What blood vessel enters the cranium to supply the brain with fresh, oxygenated blood?

- a. common carotid artery
 - b. jugular vein
 - c. internal carotid artery
 - d. aorta
-

Solution:

C

Exercise:

Problem:

Which layer of the meninges surrounds and supports the sinuses that form the route through which blood drains from the CNS?

- a. dura mater
- b. arachnoid mater
- c. subarachnoid
- d. pia mater

Solution:

A

Exercise:

Problem: What type of glial cell is responsible for filtering blood to produce CSF at the choroid plexus?

- a. ependymal cell
- b. astrocyte
- c. oligodendrocyte
- d. Schwann cell

Solution:

A

Exercise:

Problem: Which portion of the ventricular system is found within the diencephalon?

- a. lateral ventricles
- b. third ventricle
- c. cerebral aqueduct
- d. fourth ventricle

Solution:

B

Exercise:

Problem: What condition causes a stroke?

- a. inflammation of meninges
- b. lumbar puncture
- c. infection of cerebral spinal fluid
- d. disruption of blood to the brain

Solution:

D

Critical Thinking Questions

Exercise:

Problem:

Why can the circle of Willis maintain perfusion of the brain even if there is a blockage in one part of the structure?

Solution:

The structure is a circular connection of blood vessels, so that blood coming up from one of the arteries can flow in either direction around the circle and avoid any blockage or narrowing of the blood vessels.

Exercise:

Problem:

Meningitis is an inflammation of the meninges that can have severe effects on neurological function. Why is infection of this structure potentially so dangerous?

Solution:

The nerves that connect the periphery to the CNS pass through these layers of tissue and can be damaged by that inflammation, causing a loss of important neurological functions.

Glossary

anterior spinal artery

blood vessel from the merged branches of the vertebral arteries that runs along the anterior surface of the spinal cord

arachnoid granulation

outpocket of the arachnoid membrane into the dural sinuses that allows for reabsorption of CSF into the blood

arachnoid mater

middle layer of the meninges named for the spider-web-like trabeculae that extend between it and the pia mater

arachnoid trabeculae

filaments between the arachnoid and pia mater within the subarachnoid space

basilar artery

blood vessel from the merged vertebral arteries that runs along the dorsal surface of the brain stem

carotid canal

opening in the temporal bone through which the internal carotid artery enters the cranium

central canal

hollow space within the spinal cord that is the remnant of the center of the neural tube

cerebral aqueduct

connection of the ventricular system between the third and fourth ventricles located in the midbrain

choroid plexus

specialized structures containing ependymal cells lining blood capillaries that filter blood to produce CSF in the four ventricles of the brain

circle of Willis

unique anatomical arrangement of blood vessels around the base of the brain that maintains perfusion of blood into the brain even if one component of the structure is blocked or narrowed

common carotid artery

blood vessel that branches off the aorta (or the brachiocephalic artery on the right) and supplies blood to the head and neck

dura mater

tough, fibrous, outer layer of the meninges that is attached to the inner surface of the cranium and vertebral column and surrounds the entire CNS

dural sinus

any of the venous structures surrounding the brain, enclosed within the dura mater, which drain blood from the CNS to the common venous return of the jugular veins

foramen magnum

large opening in the occipital bone of the skull through which the spinal cord emerges and the vertebral arteries enter the cranium

fourth ventricle

the portion of the ventricular system that is in the region of the brain stem and opens into the subarachnoid space through the median and lateral apertures

internal carotid artery

branch from the common carotid artery that enters the cranium and supplies blood to the brain

interventricular foramina

openings between the lateral ventricles and third ventricle allowing for the passage of CSF

jugular veins

blood vessels that return "used" blood from the head and neck

lateral apertures

pair of openings from the fourth ventricle to the subarachnoid space on either side and between the medulla and cerebellum

lateral ventricles

portions of the ventricular system that are in the region of the cerebrum

lumbar puncture

procedure used to withdraw CSF from the lower lumbar region of the vertebral column that avoids the risk of damaging CNS tissue because the spinal cord ends at the upper lumbar vertebrae

median aperture

singular opening from the fourth ventricle into the subarachnoid space at the midline between the medulla and cerebellum

meninges

protective outer coverings of the CNS composed of connective tissue

occipital sinuses

dural sinuses along the edge of the occipital lobes of the cerebrum

orthostatic reflex

sympathetic function that maintains blood pressure when standing to offset the increased effect of gravity

pia mater

thin, innermost membrane of the meninges that directly covers the surface of the CNS

sigmoid sinuses

dural sinuses that drain directly into the jugular veins

straight sinus

dural sinus that drains blood from the deep center of the brain to collect with the other sinuses

subarachnoid space

space between the arachnoid mater and pia mater that contains CSF and the fibrous connections of the arachnoid trabeculae

superior sagittal sinus

dural sinus that runs along the top of the longitudinal fissure and drains blood from the majority of the outer cerebrum

third ventricle

portion of the ventricular system that is in the region of the diencephalon

transverse sinuses

dural sinuses that drain along either side of the occipital–cerebellar space

ventricles

remnants of the hollow center of the neural tube that are spaces for cerebrospinal fluid to circulate through the brain

vertebral arteries

arteries that ascend along either side of the vertebral column through the transverse foramina of the cervical vertebrae and enter the cranium through the foramen magnum

The Peripheral Nervous System

By the end of this section, you will be able to:

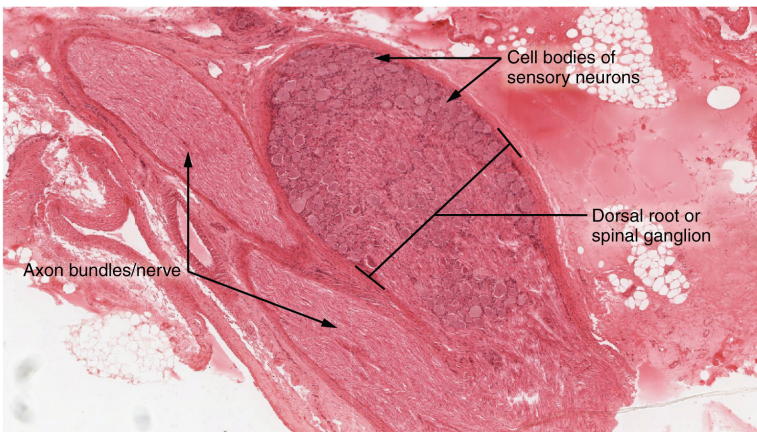
- Describe the structures found in the PNS
- Distinguish between somatic and autonomic structures, including the special peripheral structures of the enteric nervous system
- Name the twelve cranial nerves and explain the functions associated with each
- Describe the sensory and motor components of spinal nerves and the plexuses that they pass through

The PNS is not as contained as the CNS because it is defined as everything that is not the CNS. Some peripheral structures are incorporated into the other organs of the body. In describing the anatomy of the PNS, it is necessary to describe the common structures, the nerves and the ganglia, as they are found in various parts of the body. Many of the neural structures that are incorporated into other organs are features of the digestive system; these structures are known as the **enteric nervous system** and are a special subset of the PNS.

Ganglia

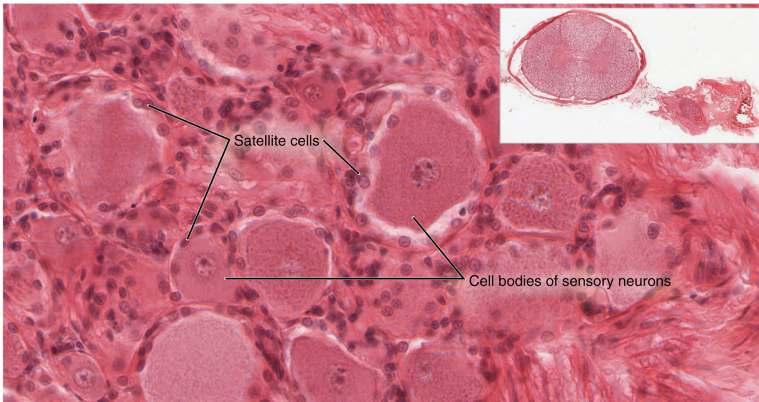
A ganglion is a group of neuron cell bodies in the periphery. Ganglia can be categorized, for the most part, as either sensory ganglia or autonomic ganglia, referring to their primary functions. The most common type of sensory ganglion is a **dorsal (posterior) root ganglion**. These ganglia are the cell bodies of neurons with axons that are sensory endings in the periphery, such as in the skin, and that extend into the CNS through the dorsal nerve root. The ganglion is an enlargement of the nerve root. Under microscopic inspection, it can be seen to include the cell bodies of the neurons, as well as bundles of fibers that are the posterior nerve root ([link](#)). The cells of the dorsal root ganglion are unipolar cells, classifying them by shape. Also, the small round nuclei of satellite cells can be seen surrounding—as if they were orbiting—the neuron cell bodies.

Dorsal Root Ganglion



The cell bodies of sensory neurons, which are unipolar neurons by shape, are seen in this photomicrograph. Also, the fibrous region is composed of the axons of these neurons that are passing through the ganglion to be part of the dorsal nerve root (tissue source: canine). LM $\times 40$. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)

Spinal Cord and Root Ganglion



The slide includes both a cross-section of the lumbar spinal cord and a section of the dorsal root ganglion (see also [link](#)) (tissue source: canine). LM $\times 1600$. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)

Note:



View the [University of Michigan WebScope](#) to explore the tissue sample in greater detail. If you zoom in on the dorsal root ganglion, you can see smaller satellite glial cells surrounding the large cell bodies of the sensory neurons. From what structure do satellite cells derive during embryologic development?

Another type of sensory ganglion is a **cranial nerve ganglion**. This is analogous to the dorsal root ganglion, except that it is associated with a **cranial nerve** instead of a **spinal nerve**. The roots of cranial nerves are within the cranium, whereas the ganglia are outside the skull. For example, the **trigeminal ganglion** is superficial to the temporal bone whereas its associated nerve is attached to the mid-pons region of the brain stem. The neurons of cranial nerve ganglia are also unipolar in shape with associated satellite cells.

The other major category of ganglia are those of the autonomic nervous system, which is divided into the sympathetic and parasympathetic nervous systems. The **sympathetic chain ganglia** constitute a row of ganglia along the vertebral column that receive central input from the lateral horn of the thoracic and upper lumbar spinal cord. Superior to the chain ganglia are three **paravertebral ganglia** in the cervical region. Three other autonomic ganglia that are related to the sympathetic chain are the **prevertebral ganglia**, which are located outside of the chain but have similar functions. They are referred to as prevertebral because they are anterior to the vertebral column. The neurons of these autonomic ganglia are multipolar in shape, with dendrites radiating out around the cell body where synapses from the spinal cord neurons are made. The neurons of the chain, paravertebral, and prevertebral ganglia then project to organs in the head and neck, thoracic, abdominal, and pelvic cavities to regulate the sympathetic aspect of homeostatic mechanisms.

Another group of autonomic ganglia are the **terminal ganglia** that receive input from cranial nerves or sacral spinal nerves and are responsible for regulating the parasympathetic aspect of homeostatic mechanisms. These two

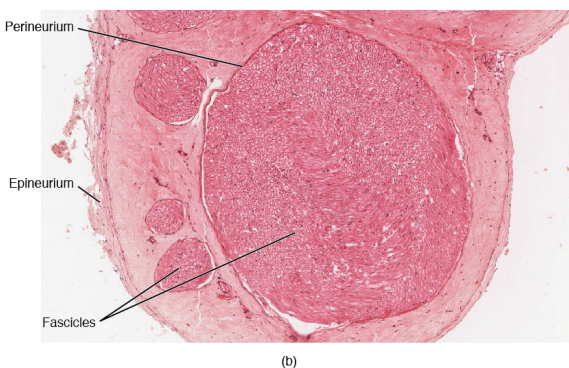
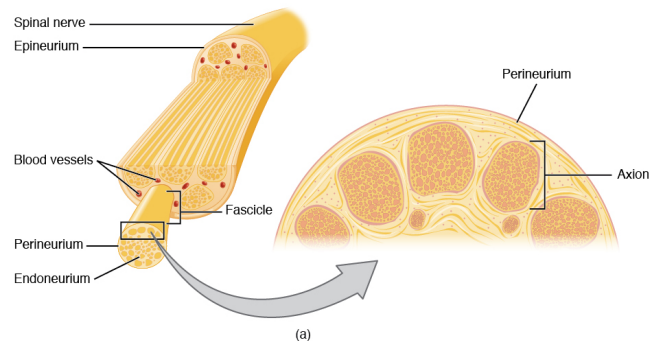
sets of ganglia, sympathetic and parasympathetic, often project to the same organs—one input from the chain ganglia and one input from a terminal ganglion—to regulate the overall function of an organ. For example, the heart receives two inputs such as these; one increases heart rate, and the other decreases it. The terminal ganglia that receive input from cranial nerves are found in the head and neck, as well as the thoracic and upper abdominal cavities, whereas the terminal ganglia that receive sacral input are in the lower abdominal and pelvic cavities.

Terminal ganglia below the head and neck are often incorporated into the wall of the target organ as a **plexus**. A plexus, in a general sense, is a network of fibers or vessels. This can apply to nervous tissue (as in this instance) or structures containing blood vessels (such as a choroid plexus). For example, the **enteric plexus** is the extensive network of axons and neurons in the wall of the small and large intestines. The enteric plexus is actually part of the enteric nervous system, along with the **gastric plexuses** and the **esophageal plexus**. Though the enteric nervous system receives input originating from central neurons of the autonomic nervous system, it does not require CNS input to function. In fact, it operates independently to regulate the digestive system.

Nerves

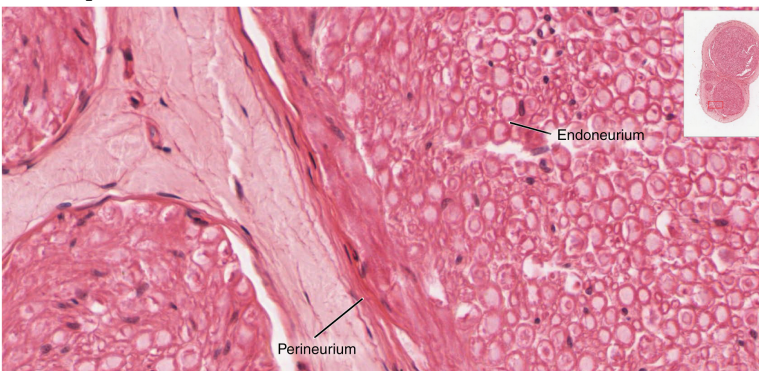
Bundles of axons in the PNS are referred to as nerves. These structures in the periphery are different than the central counterpart, called a tract. Nerves are composed of more than just nervous tissue. They have connective tissues invested in their structure, as well as blood vessels supplying the tissues with nourishment. The outer surface of a nerve is a surrounding layer of fibrous connective tissue called the **epineurium**. Within the nerve, axons are further bundled into **fascicles**, which are each surrounded by their own layer of fibrous connective tissue called **perineurium**. Finally, individual axons are surrounded by loose connective tissue called the **endoneurium** ([link](#)). These three layers are similar to the connective tissue sheaths for muscles. Nerves are associated with the region of the CNS to which they are connected, either as cranial nerves connected to the brain or spinal nerves connected to the spinal cord.

Nerve Structure



The structure of a nerve is organized by the layers of connective tissue on the outside, around each fascicle, and surrounding the individual nerve fibers (tissue source: simian). LM $\times 40$. (Micrograph provided by the Regents of University of Michigan Medical School)

Close-Up of Nerve Trunk



Zoom in on this slide of a nerve trunk to examine the endoneurium, perineurium, and epineurium in greater detail (tissue source: simian). LM $\times 1600$. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)

Note:



View the [University of Michigan WebScope](#) to explore the tissue sample in greater detail. With what structures in a skeletal muscle are the endoneurium, perineurium, and epineurium comparable?

Cranial Nerves

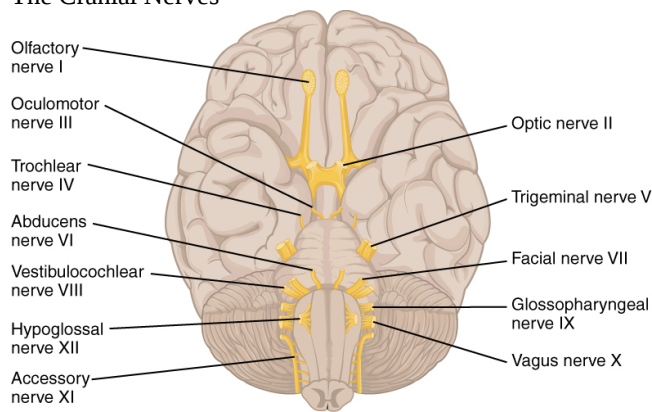
The nerves attached to the brain are the cranial nerves, which are primarily responsible for the sensory and motor functions of the head and neck (one of these nerves targets organs in the thoracic and abdominal cavities as part of the parasympathetic nervous system). There are twelve cranial nerves, which are designated CNI through CNXII for “Cranial Nerve,” using Roman numerals for 1 through 12. They can be classified as sensory nerves, motor nerves, or a combination of both, meaning that the axons in these nerves originate out of sensory ganglia external to the cranium or motor nuclei within the brain stem. Sensory axons enter the brain to synapse in a nucleus. Motor axons connect to skeletal muscles of the head or neck. Three of the nerves are solely composed of sensory fibers; five are strictly motor; and the remaining four are mixed nerves.

Learning the cranial nerves is a tradition in anatomy courses, and students have always used mnemonic devices to remember the nerve names. A traditional mnemonic is the rhyming couplet, “On Old Olympus’ Towering Tops/A Finn And German Viewed Some Hops,” in which the initial letter of each word corresponds to the initial letter in the name of each nerve. The names of the nerves have changed over the years to reflect current usage and more accurate naming. An exercise to help learn this sort of information is to generate a mnemonic using words that have personal significance. The names of the cranial nerves are listed in [\[link\]](#) along with a brief description of

their function, their source (sensory ganglion or motor nucleus), and their target (sensory nucleus or skeletal muscle). They are listed here with a brief explanation of each nerve ([link](#)).

The **olfactory nerve** and **optic nerve** are responsible for the sense of smell and vision, respectively. The **oculomotor nerve** is responsible for eye movements by controlling four of the **extraocular muscles**. It is also responsible for lifting the upper eyelid when the eyes point up, and for pupillary constriction. The **trochlear nerve** and the **abducens nerve** are both responsible for eye movement, but do so by controlling different extraocular muscles. The **trigeminal nerve** is responsible for cutaneous sensations of the face and controlling the muscles of mastication. The **facial nerve** is responsible for the muscles involved in facial expressions, as well as part of the sense of taste and the production of saliva. The **vestibulocochlear nerve** is responsible for the senses of hearing and balance. The **glossopharyngeal nerve** is responsible for controlling muscles in the oral cavity and upper throat, as well as part of the sense of taste and the production of saliva. The **vagus nerve** is responsible for contributing to homeostatic control of the organs of the thoracic and upper abdominal cavities. The **spinal accessory nerve** is responsible for controlling the muscles of the neck, along with cervical spinal nerves. The **hypoglossal nerve** is responsible for controlling the muscles of the lower throat and tongue.

The Cranial Nerves



The anatomical arrangement of the roots of the cranial nerves observed from an inferior view of the brain.

Three of the cranial nerves also contain autonomic fibers, and a fourth is almost purely a component of the autonomic system. The oculomotor, facial, and glossopharyngeal nerves contain fibers that contact autonomic ganglia. The oculomotor fibers initiate pupillary constriction, whereas the facial and glossopharyngeal fibers both initiate salivation. The vagus nerve primarily targets autonomic ganglia in the thoracic and upper abdominal cavities.

Note:



Visit this [site](#) to read about a man who wakes with a headache and a loss of vision. His regular doctor sent him to an ophthalmologist to address the vision loss. The ophthalmologist recognizes a greater problem and immediately sends him to the emergency room. Once there, the patient undergoes a large battery of tests, but a definite cause cannot be found. A specialist recognizes the problem as meningitis, but the question is what caused it originally.

How can that be cured? The loss of vision comes from swelling around the optic nerve, which probably presented as a bulge on the inside of the eye. Why is swelling related to meningitis going to push on the optic nerve?

Another important aspect of the cranial nerves that lends itself to a mnemonic is the functional role each nerve plays. The nerves fall into one of three basic groups. They are sensory, motor, or both (see [link](#)). The sentence, “Some Say Marry Money But My Brother Says Brains Beauty Matter More,” corresponds to the basic function of each nerve. The first, second, and eighth nerves are purely sensory: the olfactory (CNI), optic (CNII), and vestibulocochlear (CNVIII) nerves. The three eye-movement nerves are all motor: the oculomotor (CNIII), trochlear (CNIV), and abducens (CNVI). The spinal accessory (CNXI) and hypoglossal (CNXII) nerves are also strictly motor. The remainder of the nerves contain both sensory and motor fibers. They are the trigeminal (CNV), facial (CNVII), glossopharyngeal (CNIX), and vagus (CNX) nerves. The nerves that convey both are often related to each other. The trigeminal and facial nerves both concern the face; one concerns the sensations and the other concerns the muscle movements. The facial and glossopharyngeal nerves are both responsible for conveying gustatory, or taste, sensations as well as controlling salivary glands. The vagus nerve is involved in visceral responses to taste, namely the gag reflex. This is not an exhaustive list of what these combination nerves do, but there is a thread of relation between them.

Cranial Nerves					
Mnemonic	#	Name	Function (S/M/B)	Central connection (nuclei)	
On	I	Olfactory	Smell (S)	Olfactory bulb	
Old	II	Optic	Vision (S)	Hypothalamus/thalamus/midbrain	
Olympus'	III	Oculomotor	Eye movements (M)	Oculomotor nucleus	
Towering	IV	Trochlear	Eye movements (M)	Trochlear nucleus	
Tops	V	Trigeminal	Sensory/motor – face (B)	Trigeminal nuclei in the midbrain, pons, and medulla	
A	VI	Abducens	Eye movements (M)	Abducens nucleus	

Cranial Nerves					
Mnemonic	#	Name	Function (S/M/B)	Central connection (nuclei)	
Finn	VII	Facial	Motor – face, Taste (B)	Facial nucleus, solitary nucleus, superior salivatory nucleus	
And	VIII	Auditory (Vestibulocochlear)	Hearing/balance (S)	Cochlear nucleus, Vestibular nucleus/cerebellum	
German	IX	Glossopharyngeal	Motor – throat Taste (B)	Solitary nucleus, inferior salivatory nucleus, nucleus ambiguus	
Viewed	X	Vagus	Motor/sensory – viscera (autonomic) (B)	Medulla	
Some	XI	Spinal Accessory	Motor – head and neck (M)	Spinal accessory nucleus	
Hops	XII	Hypoglossal	Motor – lower throat (M)	Hypoglossal nucleus	

Spinal Nerves

The nerves connected to the spinal cord are the spinal nerves. The arrangement of these nerves is much more regular than that of the cranial nerves. All of the spinal nerves are combined sensory and motor axons that separate into two nerve roots. The sensory axons enter the spinal cord as the dorsal nerve root. The motor fibers, both somatic and autonomic, emerge as the ventral nerve root. The dorsal root ganglion for each nerve is an enlargement of the spinal nerve.

There are 31 spinal nerves, named for the level of the spinal cord at which each one emerges. There are eight pairs of cervical nerves designated C1 to C8, twelve thoracic nerves designated T1 to T12, five pairs of lumbar nerves

designated L1 to L5, five pairs of sacral nerves designated S1 to S5, and one pair of coccygeal nerves. The nerves are numbered from the superior to inferior positions, and each emerges from the vertebral column through the intervertebral foramen at its level. The first nerve, C1, emerges between the first cervical vertebra and the occipital bone. The second nerve, C2, emerges between the first and second cervical vertebrae. The same occurs for C3 to C7, but C8 emerges between the seventh cervical vertebra and the first thoracic vertebra. For the thoracic and lumbar nerves, each one emerges between the vertebra that has the same designation and the next vertebra in the column. The sacral nerves emerge from the sacral foramina along the length of that unique vertebra.

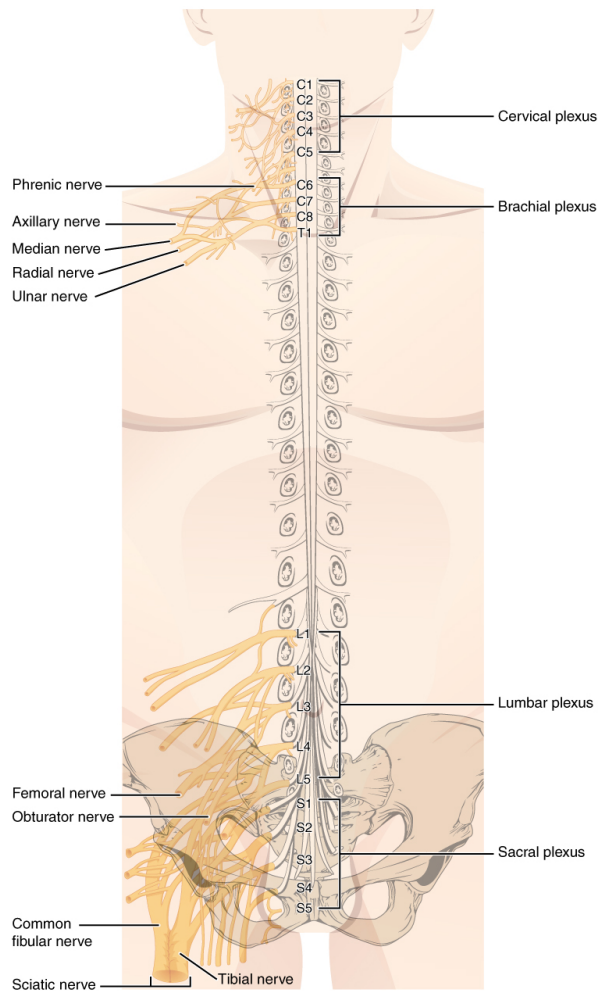
Spinal nerves extend outward from the vertebral column to enervate the periphery. The nerves in the periphery are not straight continuations of the spinal nerves, but rather the reorganization of the axons in those nerves to follow different courses. Axons from different spinal nerves will come together into a **systemic nerve**. This occurs at four places along the length of the vertebral column, each identified as a **nerve plexus**, whereas the other spinal nerves directly correspond to nerves at their respective levels. In this instance, the word plexus is used to describe networks of nerve fibers with no associated cell bodies.

Of the four nerve plexuses, two are found at the cervical level, one at the lumbar level, and one at the sacral level ([link](#)). The **cervical plexus** is composed of axons from spinal nerves C1 through C5 and branches into nerves in the posterior neck and head, as well as the **phrenic nerve**, which connects to the diaphragm at the base of the thoracic cavity. The other plexus from the cervical level is the **brachial plexus**. Spinal nerves C4 through T1 reorganize through this plexus to give rise to the nerves of the arms, as the name brachial suggests. A large nerve from this plexus is the **radial nerve** from which the **axillary nerve** branches to go to the armpit region. The radial nerve continues through the arm and is paralleled by the **ulnar nerve** and the **median nerve**. The **lumbar plexus** arises from all the lumbar spinal nerves and gives rise to nerves enervating the pelvic region and the anterior leg. The **femoral nerve** is one of the major nerves from this plexus, which gives rise to the **saphenous nerve** as a branch that extends through the anterior lower leg. The **sacral plexus** comes from the lower lumbar nerves L4 and L5 and the sacral nerves S1 to S4. The most significant systemic nerve to come from this plexus is the **sciatic nerve**, which is a combination of the **tibial nerve** and the **fibular nerve**. The sciatic nerve extends across the hip joint and is most commonly associated with the condition **sciatica**, which is the result of compression or irritation of the nerve or any of the spinal nerves giving rise to it.

These plexuses are described as arising from spinal nerves and giving rise to certain systemic nerves, but they contain fibers that serve sensory functions or fibers that serve motor functions. This means that some fibers extend from cutaneous or other peripheral sensory surfaces and send action potentials into the CNS. Those are axons of sensory neurons in the dorsal root ganglia that enter the spinal cord through the dorsal nerve root. Other fibers are the axons of motor neurons of the anterior horn of the spinal cord, which emerge in the ventral nerve root and send action potentials to cause skeletal muscles to contract in their target regions. For example, the radial nerve contains fibers of cutaneous sensation in the arm, as well as motor fibers that move muscles in the arm.

Spinal nerves of the thoracic region, T2 through T11, are not part of the plexuses but rather emerge and give rise to the **intercostal nerves** found between the ribs, which articulate with the vertebrae surrounding the spinal nerve.

Nerve Plexuses of the Body



There are four main nerve plexuses in the human body. The cervical plexus supplies nerves to the posterior head and neck, as well as to the diaphragm. The brachial plexus supplies nerves to the arm. The lumbar plexus supplies nerves to the anterior leg. The sacral plexus supplies nerves to the posterior leg.

Note:

Aging and the...

Nervous System

Anosmia is the loss of the sense of smell. It is often the result of the olfactory nerve being severed, usually because of blunt force trauma to the head. The sensory neurons of the olfactory epithelium have a limited lifespan of approximately one to four months, and new ones are made on a regular basis. The new neurons extend their axons into the CNS by growing along the existing fibers of the olfactory nerve. The ability of these neurons to be replaced is lost with age. Age-related anosmia is not the result of impact trauma to the head, but rather a slow loss of the sensory neurons with no new neurons born to replace them.

Smell is an important sense, especially for the enjoyment of food. There are only five tastes sensed by the tongue, and two of them are generally thought of as unpleasant tastes (sour and bitter). The rich sensory experience of

food is the result of odor molecules associated with the food, both as food is moved into the mouth, and therefore passes under the nose, and when it is chewed and molecules are released to move up the pharynx into the posterior nasal cavity. Anosmia results in a loss of the enjoyment of food.

As the replacement of olfactory neurons declines with age, anosmia can set in. Without the sense of smell, many sufferers complain of food tasting bland. Often, the only way to enjoy food is to add seasoning that can be sensed on the tongue, which usually means adding table salt. The problem with this solution, however, is that this increases sodium intake, which can lead to cardiovascular problems through water retention and the associated increase in blood pressure.

Chapter Review

The PNS is composed of the groups of neurons (ganglia) and bundles of axons (nerves) that are outside of the brain and spinal cord. Ganglia are of two types, sensory or autonomic. Sensory ganglia contain unipolar sensory neurons and are found on the dorsal root of all spinal nerves as well as associated with many of the cranial nerves. Autonomic ganglia are in the sympathetic chain, the associated paravertebral or prevertebral ganglia, or in terminal ganglia near or within the organs controlled by the autonomic nervous system.

Nerves are classified as cranial nerves or spinal nerves on the basis of their connection to the brain or spinal cord, respectively. The twelve cranial nerves can be strictly sensory in function, strictly motor in function, or a combination of the two functions. Sensory fibers are axons of sensory ganglia that carry sensory information into the brain and target sensory nuclei. Motor fibers are axons of motor neurons in motor nuclei of the brain stem and target skeletal muscles of the head and neck. Spinal nerves are all mixed nerves with both sensory and motor fibers. Spinal nerves emerge from the spinal cord and reorganize through plexuses, which then give rise to systemic nerves. Thoracic spinal nerves are not part of any plexus, but give rise to the intercostal nerves directly.

Interactive Link Questions

Exercise:

Problem:

[\[link\]](#) If you zoom in on the DRG, you can see smaller satellite glial cells surrounding the large cell bodies of the sensory neurons. From what structure do satellite cells derive during embryologic development?

Solution:

[\[link\]](#) They derive from the neural crest.

Exercise:

Problem:

[\[link\]](#) To what structures in a skeletal muscle are the endoneurium, perineurium, and epineurium comparable?

Solution:

[\[link\]](#) The endoneurium surrounding individual nerve fibers is comparable to the endomysium surrounding myofibrils, the perineurium bundling axons into fascicles is comparable to the perimysium bundling muscle fibers into fascicles, and the epineurium surrounding the whole nerve is comparable to the epimysium surrounding the muscle.

Exercise:

Problem:

Visit this [site](#) to read about a man who wakes with a headache and a loss of vision. His regular doctor sent him to an ophthalmologist to address the vision loss. The ophthalmologist recognizes a greater problem and immediately sends him to the emergency room. Once there, the patient undergoes a large battery of tests, but a definite cause cannot be found. A specialist recognizes the problem as meningitis, but the question is what caused it originally. How can that be cured? The loss of vision comes from swelling around the optic nerve, which probably presented as a bulge on the inside of the eye. Why is swelling related to meningitis going to push on the optic nerve?

Solution:

The optic nerve enters the CNS in its projection from the eyes in the periphery, which means that it crosses through the meninges. Meningitis will include swelling of those protective layers of the CNS, resulting in pressure on the optic nerve, which can compromise vision.

Review Questions**Exercise:**

Problem: What type of ganglion contains neurons that control homeostatic mechanisms of the body?

- a. sensory ganglion
 - b. dorsal root ganglion
 - c. autonomic ganglion
 - d. cranial nerve ganglion
-

Solution:

C

Exercise:

Problem: Which ganglion is responsible for cutaneous sensations of the face?

- a. otic ganglion
 - b. vestibular ganglion
 - c. geniculate ganglion
 - d. trigeminal ganglion
-

Solution:

D

Exercise:

Problem: What is the name for a bundle of axons within a nerve?

- a. fascicle
- b. tract
- c. nerve root
- d. epineurium

Solution:

A

Exercise:

Problem: Which cranial nerve does not control functions in the head and neck?

- a. olfactory
- b. trochlear
- c. glossopharyngeal
- d. vagus

Solution:

D

Exercise:

Problem: Which of these structures is not under direct control of the peripheral nervous system?

- a. trigeminal ganglion
- b. gastric plexus
- c. sympathetic chain ganglia
- d. cervical plexus

Solution:

B

Critical Thinking Questions

Exercise:

Problem: Why are ganglia and nerves not surrounded by protective structures like the meninges of the CNS?

Solution:

The peripheral nervous tissues are out in the body, sometimes part of other organ systems. There is not a privileged blood supply like there is to the brain and spinal cord, so peripheral nervous tissues do not need the same sort of protections.

Exercise:

Problem:

Testing for neurological function involves a series of tests of functions associated with the cranial nerves. What functions, and therefore which nerves, are being tested by asking a patient to follow the tip of a pen with their eyes?

Solution:

The contraction of extraocular muscles is being tested, which is the function of the oculomotor, trochlear, and abducens nerves.

Glossary

abducens nerve

sixth cranial nerve; responsible for contraction of one of the extraocular muscles

axillary nerve

systemic nerve of the arm that arises from the brachial plexus

brachial plexus

nerve plexus associated with the lower cervical spinal nerves and first thoracic spinal nerve

cervical plexus

nerve plexus associated with the upper cervical spinal nerves

cranial nerve

one of twelve nerves connected to the brain that are responsible for sensory or motor functions of the head and neck

cranial nerve ganglion

sensory ganglion of cranial nerves

dorsal (posterior) root ganglion

sensory ganglion attached to the posterior nerve root of a spinal nerve

endoneurium

innermost layer of connective tissue that surrounds individual axons within a nerve

enteric nervous system

peripheral structures, namely ganglia and nerves, that are incorporated into the digestive system organs

enteric plexus

neuronal plexus in the wall of the intestines, which is part of the enteric nervous system

epineurium

outermost layer of connective tissue that surrounds an entire nerve

esophageal plexus

neuronal plexus in the wall of the esophagus that is part of the enteric nervous system

extraocular muscles

six skeletal muscles that control eye movement within the orbit

facial nerve

seventh cranial nerve; responsible for contraction of the facial muscles and for part of the sense of taste, as well as causing saliva production

fascicle

small bundles of nerve or muscle fibers enclosed by connective tissue

femoral nerve

systemic nerve of the anterior leg that arises from the lumbar plexus

fibular nerve

systemic nerve of the posterior leg that begins as part of the sciatic nerve

gastric plexuses

neuronal networks in the wall of the stomach that are part of the enteric nervous system

glossopharyngeal nerve

ninth cranial nerve; responsible for contraction of muscles in the tongue and throat and for part of the sense of taste, as well as causing saliva production

hypoglossal nerve

twelfth cranial nerve; responsible for contraction of muscles of the tongue

intercostal nerve

systemic nerve in the thoracic cavity that is found between two ribs

lumbar plexus

nerve plexus associated with the lumbar spinal nerves

median nerve

systemic nerve of the arm, located between the ulnar and radial nerves

nerve plexus

network of nerves without neuronal cell bodies included

oculomotor nerve

third cranial nerve; responsible for contraction of four of the extraocular muscles, the muscle in the upper eyelid, and pupillary constriction

olfactory nerve

first cranial nerve; responsible for the sense of smell

optic nerve

second cranial nerve; responsible for visual sensation

paravertebral ganglia

autonomic ganglia superior to the sympathetic chain ganglia

perineurium

layer of connective tissue surrounding fascicles within a nerve

phrenic nerve

systemic nerve from the cervical plexus that innervates the diaphragm

plexus

network of nerves or nervous tissue

prevertebral ganglia

autonomic ganglia that are anterior to the vertebral column and functionally related to the sympathetic chain ganglia

radial nerve

systemic nerve of the arm, the distal component of which is located near the radial bone

sacral plexus

nerve plexus associated with the lower lumbar and sacral spinal nerves

saphenous nerve

systemic nerve of the lower anterior leg that is a branch from the femoral nerve

sciatic nerve

systemic nerve from the sacral plexus that is a combination of the tibial and fibular nerves and extends across the hip joint and gluteal region into the upper posterior leg

sciatica

painful condition resulting from inflammation or compression of the sciatic nerve or any of the spinal nerves that contribute to it

spinal accessory nerve

eleventh cranial nerve; responsible for contraction of neck muscles

spinal nerve

one of 31 nerves connected to the spinal cord

sympathetic chain ganglia

autonomic ganglia in a chain along the anterolateral aspect of the vertebral column that are responsible for contributing to homeostatic mechanisms of the autonomic nervous system

systemic nerve

nerve in the periphery distal to a nerve plexus or spinal nerve

terminal ganglion

autonomic ganglia that are near or within the walls of organs that are responsible for contributing to homeostatic mechanisms of the autonomic nervous system

tibial nerve

systemic nerve of the posterior leg that begins as part of the sciatic nerve

trigeminal ganglion

sensory ganglion that contributes sensory fibers to the trigeminal nerve

trigeminal nerve

fifth cranial nerve; responsible for cutaneous sensation of the face and contraction of the muscles of mastication

trochlear nerve

fourth cranial nerve; responsible for contraction of one of the extraocular muscles

ulnar nerve

systemic nerve of the arm located close to the ulna, a bone of the forearm

vagus nerve

tenth cranial nerve; responsible for the autonomic control of organs in the thoracic and upper abdominal cavities

vestibulocochlear nerve

eighth cranial nerve; responsible for the sensations of hearing and balance

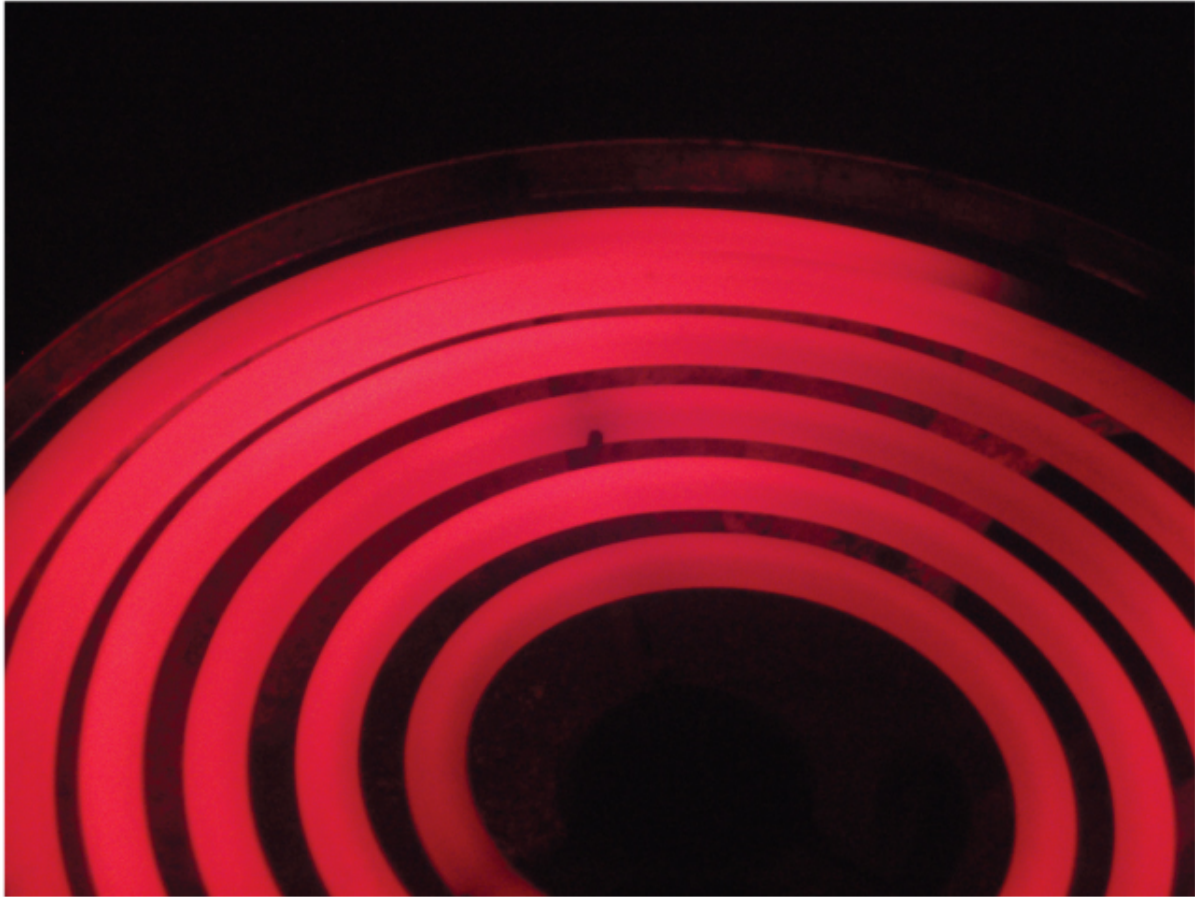
Introduction

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Too Hot to Touch

When high temperature is sensed in the skin, a reflexive withdrawal is initiated by the muscles of the arm.

Sensory neurons are activated by a stimulus, which is sent to the central nervous system, and a motor response is sent out to the skeletal muscles that control this movement.



Note:

Chapter Objectives

After studying this chapter, you will be able to:

- Describe the components of the somatic nervous system
- Name the modalities and submodalities of the sensory systems
- Distinguish between general and special senses
- Describe regions of the central nervous system that contribute to somatic functions
- Explain the stimulus-response motor pathway

The somatic nervous system is traditionally considered a division within the peripheral nervous system. However, this misses an important point: somatic refers to a functional division, whereas peripheral refers to an anatomic division. The somatic nervous system is responsible for our conscious perception of the environment and for our voluntary responses to that perception by means of skeletal muscles. Peripheral sensory neurons receive input from environmental stimuli, but the neurons that produce motor responses originate in the central nervous system. The distinction between the structures (i.e., anatomy) of the peripheral and central nervous systems and functions (i.e., physiology) of the somatic and autonomic systems can most easily be demonstrated through a simple reflex action. When you touch a hot stove, you pull your hand away. Sensory receptors in the skin sense extreme temperature and the early signs of tissue damage. This triggers an action potential, which travels along the sensory fiber from the skin, through the dorsal spinal root to the spinal cord, and directly activates a ventral horn motor neuron. That neuron sends a signal along its axon to excite the biceps brachii, causing contraction of the muscle and flexion of the forearm at the elbow to withdraw the hand from the hot stove. The withdrawal reflex has more components, such as inhibiting the opposing muscle and balancing posture while the arm is forcefully withdrawn, which will be further explored at the end of this chapter.

The basic withdrawal reflex explained above includes sensory input (the painful stimulus), central processing (the synapse in the spinal cord), and motor output (activation of a ventral motor neuron that causes contraction of the biceps brachii). Expanding the explanation of the withdrawal reflex can include inhibition of the opposing muscle, or cross extension, either of which increase the complexity of the example by involving more central neurons. A collateral branch of the sensory axon would inhibit another ventral horn motor neuron so that the triceps brachii do not contract and slow the withdrawal down. The cross extensor reflex provides a counterbalancing movement on the other side of the body, which requires another collateral of the sensory axon to activate contraction of the extensor muscles in the contralateral limb.

A more complex example of somatic function is conscious muscle movement. For example, reading of this text starts with visual sensory input

to the retina, which then projects to the thalamus, and on to the cerebral cortex. A sequence of regions of the cerebral cortex process the visual information, starting in the primary visual cortex of the occipital lobe, and resulting in the conscious perception of these letters. Subsequent cognitive processing results in understanding of the content. As you continue reading, regions of the cerebral cortex in the frontal lobe plan how to move the eyes to follow the lines of text. The output from the cortex causes activity in motor neurons in the brain stem that cause movement of the extraocular muscles through the third, fourth, and sixth cranial nerves. This example also includes sensory input (the retinal projection to the thalamus), central processing (the thalamus and subsequent cortical activity), and motor output (activation of neurons in the brain stem that lead to coordinated contraction of extraocular muscles).

Sensory Perception

By the end of this section, you will be able to:

- Describe different types of sensory receptors
- Describe the structures responsible for the special senses of taste, smell, hearing, balance, and vision
- Distinguish how different tastes are transduced
- Describe the means of mechanoreception for hearing and balance
- List the supporting structures around the eye and describe the structure of the eyeball
- Describe the processes of phototransduction

A major role of sensory receptors is to help us learn about the environment around us, or about the state of our internal environment. Stimuli from varying sources, and of different types, are received and changed into the electrochemical signals of the nervous system. This occurs when a stimulus changes the cell membrane potential of a sensory neuron. The stimulus causes the sensory cell to produce an action potential that is relayed into the central nervous system (CNS), where it is integrated with other sensory information—or sometimes higher cognitive functions—to become a conscious perception of that stimulus. The central integration may then lead to a motor response.

Describing sensory function with the term sensation or perception is a deliberate distinction. Sensation is the activation of sensory receptor cells at the level of the stimulus. Perception is the central processing of sensory stimuli into a meaningful pattern. Perception is dependent on sensation, but not all sensations are perceived. Receptors are the cells or structures that detect sensations. A receptor cell is changed directly by a stimulus. A transmembrane protein receptor is a protein in the cell membrane that mediates a physiological change in a neuron, most often through the opening of ion channels or changes in the cell signaling processes. Transmembrane receptors are activated by chemicals called ligands. For example, a molecule in food can serve as a ligand for taste receptors. Other transmembrane proteins, which are not accurately called receptors, are sensitive to mechanical or thermal changes. Physical changes in these proteins increase ion flow across the membrane, and can generate an action potential or a graded potential in the sensory neurons.

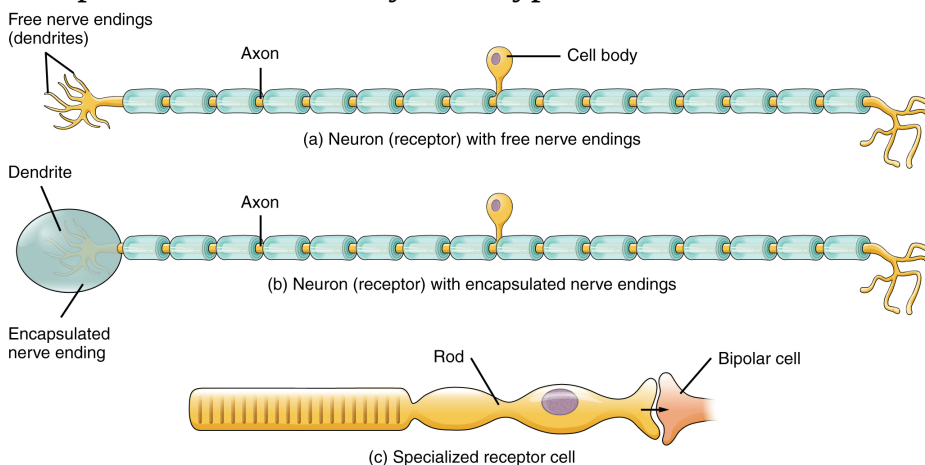
Sensory Receptors

Stimuli in the environment activate specialized receptor cells in the peripheral nervous system. Different types of stimuli are sensed by different types of receptor cells. Receptor cells can be classified into types on the basis of three different criteria: cell type, position, and function. Receptors can be classified structurally on the basis of cell type and their position in relation to stimuli they sense. They can also be classified functionally on the basis of the **transduction** of stimuli, or how the mechanical stimulus, light, or chemical changed the cell membrane potential.

Structural Receptor Types

The cells that interpret information about the environment can be either (1) a neuron that has a **free nerve ending**, with dendrites embedded in tissue that would receive a sensation; (2) a neuron that has an **encapsulated ending** in which the sensory nerve endings are encapsulated in connective tissue that enhances their sensitivity; or (3) a specialized **receptor cell**, which has distinct structural components that interpret a specific type of stimulus ([\[link\]](#)). The pain and temperature receptors in the dermis of the skin are examples of neurons that have free nerve endings. Also located in the dermis of the skin are lamellated corpuscles, neurons with encapsulated nerve endings that respond to pressure and touch. The cells in the retina that respond to light stimuli are an example of a specialized receptor, a **photoreceptor**.

Receptor Classification by Cell Type



Receptor cell types can be classified on the basis of their structure. Sensory neurons can have either (a) free nerve endings or (b) encapsulated endings.

Photoreceptors in the eyes, such as rod cells, are examples of (c) specialized receptor cells. These cells release neurotransmitters onto a bipolar cell, which then synapses with the optic nerve neurons.

Another way that receptors can be classified is based on their location relative to the stimuli. An **exteroceptor** is a receptor that is located near a stimulus in the external environment, such as the somatosensory receptors that are located in the skin. An **interoceptor** is one that interprets stimuli from internal organs and tissues, such as the receptors that sense the increase in blood pressure in the aorta or carotid sinus. Finally, a **proprioceptor** is a receptor located near a moving part of the body, such as a muscle, that interprets the positions of the tissues as they move.

Functional Receptor Types

A third classification of receptors is by how the receptor transduces stimuli into membrane potential changes. Stimuli are of three general types. Some stimuli are ions and macromolecules that affect transmembrane receptor proteins when these chemicals diffuse across the cell membrane. Some stimuli are physical variations in the environment that affect receptor cell membrane potentials. Other stimuli include the electromagnetic radiation from visible light. For humans, the only electromagnetic energy that is perceived by our eyes is visible light. Some other organisms have receptors that humans lack, such as the heat sensors of snakes, the ultraviolet light sensors of bees, or magnetic receptors in migratory birds.

Receptor cells can be further categorized on the basis of the type of stimuli they transduce. Chemical stimuli can be interpreted by a **chemoreceptor** that interprets chemical stimuli, such as an object's taste or smell. **Osmoreceptors** respond to solute concentrations of body fluids. Additionally, pain is primarily a chemical sense that interprets the presence of chemicals from tissue damage, or similar intense stimuli, through a **nociceptor**. Physical stimuli, such as pressure and vibration, as well as the sensation of sound and body position (balance), are interpreted through a **mechanoreceptor**. Another physical

stimulus that has its own type of receptor is temperature, which is sensed through a **thermoreceptor** that is either sensitive to temperatures above (heat) or below (cold) normal body temperature.

Sensory Modalities

Ask anyone what the senses are, and they are likely to list the five major senses—taste, smell, touch, hearing, and sight. However, these are not all of the senses. The most obvious omission from this list is balance. Also, what is referred to simply as touch can be further subdivided into pressure, vibration, stretch, and hair-follicle position, on the basis of the type of mechanoreceptors that perceive these touch sensations. Other overlooked senses include temperature perception by thermoreceptors and pain perception by nociceptors.

Within the realm of physiology, senses can be classified as either general or specific. A **general sense** is one that is distributed throughout the body and has receptor cells within the structures of other organs. Mechanoreceptors in the skin, muscles, or the walls of blood vessels are examples of this type. General senses often contribute to the sense of touch, as described above, or to **proprioception** (body movement) and **kinesthesia** (body movement), or to a **visceral sense**, which is most important to autonomic functions. A **special sense** is one that has a specific organ devoted to it, namely the eye, inner ear, tongue, or nose.

Each of the senses is referred to as a **sensory modality**. Modality refers to the way that information is encoded, which is similar to the idea of transduction. The main sensory modalities can be described on the basis of how each is transduced. The chemical senses are taste and smell. The general sense that is usually referred to as touch includes chemical sensation in the form of nociception, or pain. Pressure, vibration, muscle stretch, and the movement of hair by an external stimulus, are all sensed by mechanoreceptors. Hearing and balance are also sensed by mechanoreceptors. Finally, vision involves the activation of photoreceptors.

Listing all the different sensory modalities, which can number as many as 17, involves separating the five major senses into more specific categories, or **submodalities**, of the larger sense. An individual sensory modality represents the sensation of a specific type of stimulus. For example, the general sense of

touch, which is known as **somatosensation**, can be separated into light pressure, deep pressure, vibration, itch, pain, temperature, or hair movement.

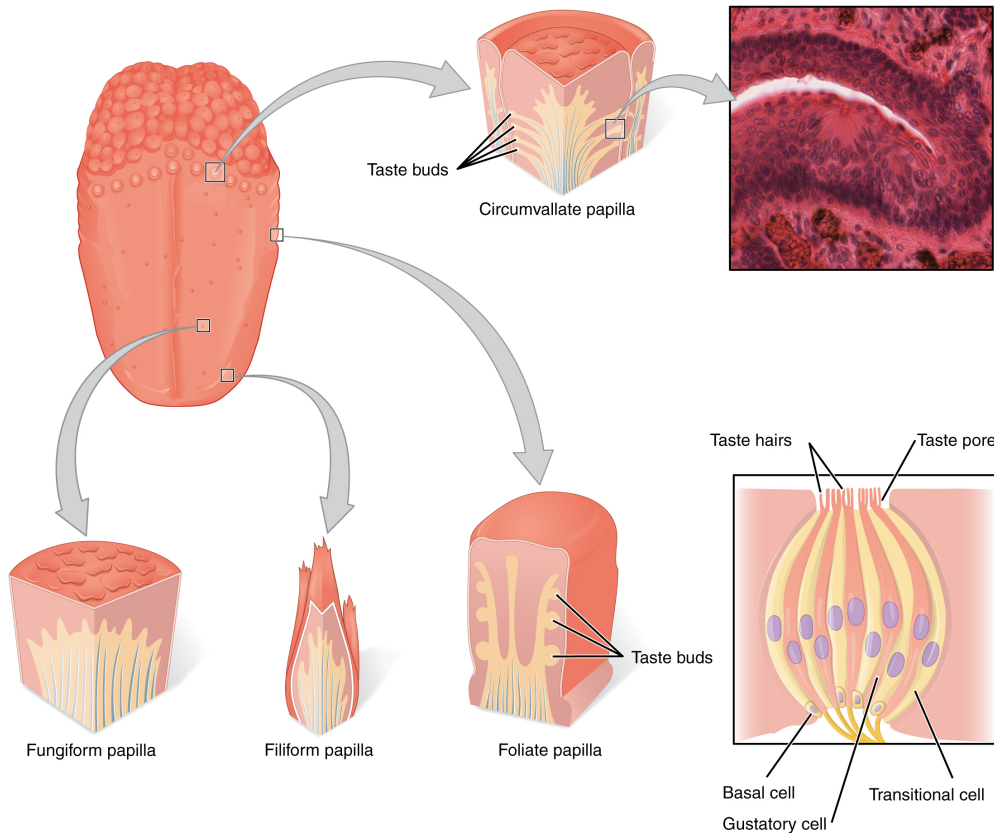
Gustation (Taste)

Only a few recognized submodalities exist within the sense of taste, or **gustation**. Until recently, only four tastes were recognized: sweet, salty, sour, and bitter. Research at the turn of the 20th century led to recognition of the fifth taste, umami, during the mid-1980s. **Umami** is a Japanese word that means “delicious taste,” and is often translated to mean savory. Very recent research has suggested that there may also be a sixth taste for fats, or lipids.

Gustation is the special sense associated with the tongue. The surface of the tongue, along with the rest of the oral cavity, is lined by a stratified squamous epithelium. Raised bumps called **papillae** (singular = papilla) contain the structures for gustatory transduction. There are four types of papillae, based on their appearance ([link](#)): circumvallate, foliate, filiform, and fungiform.

Within the structure of the papillae are **taste buds** that contain specialized **gustatory receptor cells** for the transduction of taste stimuli. These receptor cells are sensitive to the chemicals contained within foods that are ingested, and they release neurotransmitters based on the amount of the chemical in the food. Neurotransmitters from the gustatory cells can activate sensory neurons in the facial, glossopharyngeal, and vagus cranial nerves.

The Tongue



The tongue is covered with small bumps, called papillae, which contain taste buds that are sensitive to chemicals in ingested food or drink. Different types of papillae are found in different regions of the tongue. The taste buds contain specialized gustatory receptor cells that respond to chemical stimuli dissolved in the saliva. These receptor cells activate sensory neurons that are part of the facial and glossopharyngeal nerves. LM $\times 1600$. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)

Salty taste is simply the perception of sodium ions (Na^+) in the saliva. When you eat something salty, the salt crystals dissociate into the component ions Na^+ and Cl^- , which dissolve into the saliva in your mouth. The Na^+ concentration becomes high outside the gustatory cells, creating a strong concentration gradient that drives the diffusion of the ion into the cells. The

entry of Na^+ into these cells results in the depolarization of the cell membrane and the generation of a receptor potential.

Sour taste is the perception of H^+ concentration. Just as with sodium ions in salty flavors, these hydrogen ions enter the cell and trigger depolarization. Sour flavors are, essentially, the perception of acids in our food. Increasing hydrogen ion concentrations in the saliva (lowering saliva pH) triggers progressively stronger graded potentials in the gustatory cells. For example, orange juice—which contains citric acid—will taste sour because it has a pH value of approximately 3. Of course, it is often sweetened so that the sour taste is masked.

The first two tastes (salty and sour) are triggered by the cations Na^+ and H^+ . The other tastes result from food molecules binding to a G protein–coupled receptor. A G protein signal transduction system ultimately leads to depolarization of the gustatory cell. The sweet taste is the sensitivity of gustatory cells to the presence of glucose dissolved in the saliva. Other monosaccharides such as fructose, or artificial sweeteners such as aspartame (NutraSweet™), saccharine, or sucralose (Splenda™) also activate the sweet receptors. The affinity for each of these molecules varies, and some will taste sweeter than glucose because they bind to the G protein–coupled receptor differently.

Bitter taste is similar to sweet in that food molecules bind to G protein–coupled receptors. However, there are a number of different ways in which this can happen because there are a large diversity of bitter-tasting molecules. Some bitter molecules depolarize gustatory cells, whereas others hyperpolarize gustatory cells. Likewise, some bitter molecules increase G protein activation within the gustatory cells, whereas other bitter molecules decrease G protein activation. The specific response depends on which molecule is binding to the receptor.

One major group of bitter-tasting molecules are alkaloids. **Alkaloids** are nitrogen containing molecules that are commonly found in bitter-tasting plant products, such as coffee, hops (in beer), tannins (in wine), tea, and aspirin. By containing toxic alkaloids, the plant is less susceptible to microbe infection and less attractive to herbivores.

Therefore, the function of bitter taste may primarily be related to stimulating the gag reflex to avoid ingesting poisons. Because of this, many bitter foods that are normally ingested are often combined with a sweet component to make them more palatable (cream and sugar in coffee, for example). The highest concentration of bitter receptors appear to be in the posterior tongue, where a gag reflex could still spit out poisonous food.

The taste known as umami is often referred to as the savory taste. Like sweet and bitter, it is based on the activation of G protein–coupled receptors by a specific molecule. The molecule that activates this receptor is the amino acid L-glutamate. Therefore, the umami flavor is often perceived while eating protein-rich foods. Not surprisingly, dishes that contain meat are often described as savory.

Once the gustatory cells are activated by the taste molecules, they release neurotransmitters onto the dendrites of sensory neurons. These neurons are part of the facial and glossopharyngeal cranial nerves, as well as a component within the vagus nerve dedicated to the gag reflex. The facial nerve connects to taste buds in the anterior third of the tongue. The glossopharyngeal nerve connects to taste buds in the posterior two thirds of the tongue. The vagus nerve connects to taste buds in the extreme posterior of the tongue, verging on the pharynx, which are more sensitive to noxious stimuli such as bitterness.

Note:



Watch this [video](#) to learn about Dr. Danielle Reed of the Monell Chemical Senses Center in Philadelphia, Pennsylvania, who became interested in science at an early age because of her sensory experiences. She recognized that her sense of taste was unique compared with other people she knew. Now, she studies the genetic differences between people and their sensitivities to taste stimuli. In the video, there is a brief image of a person sticking out their

tongue, which has been covered with a colored dye. This is how Dr. Reed is able to visualize and count papillae on the surface of the tongue. People fall into two groups known as “tasters” and “non-tasters” based on the density of papillae on their tongue, which also indicates the number of taste buds. Non-tasters can taste food, but they are not as sensitive to certain tastes, such as bitterness. Dr. Reed discovered that she is a non-taster, which explains why she perceived bitterness differently than other people she knew. Are you very sensitive to tastes? Can you see any similarities among the members of your family?

Olfaction (Smell)

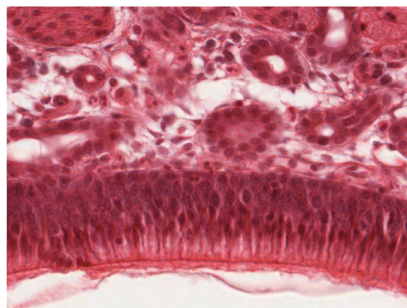
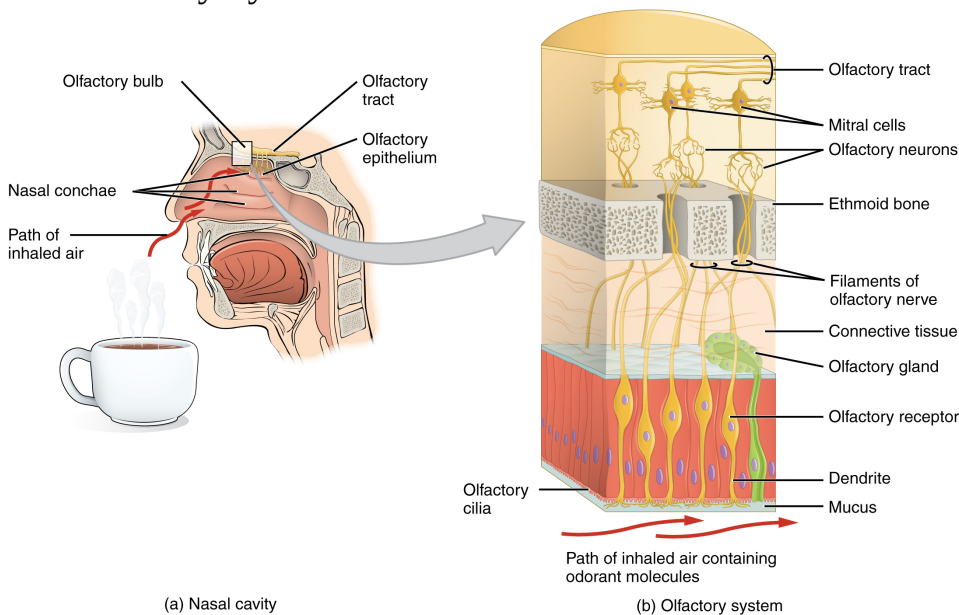
Like taste, the sense of smell, or **olfaction**, is also responsive to chemical stimuli. The olfactory receptor neurons are located in a small region within the superior nasal cavity ([\[link\]](#)). This region is referred to as the **olfactory epithelium** and contains bipolar sensory neurons. Each **olfactory sensory neuron** has dendrites that extend from the apical surface of the epithelium into the mucus lining the cavity. As airborne molecules are inhaled through the nose, they pass over the olfactory epithelial region and dissolve into the mucus. These **odorant molecules** bind to proteins that keep them dissolved in the mucus and help transport them to the olfactory dendrites. The odorant–protein complex binds to a receptor protein within the cell membrane of an olfactory dendrite. These receptors are G protein–coupled, and will produce a graded membrane potential in the olfactory neurons.

The axon of an olfactory neuron extends from the basal surface of the epithelium, through an olfactory foramen in the cribriform plate of the ethmoid bone, and into the brain. The group of axons called the olfactory tract connect to the **olfactory bulb** on the ventral surface of the frontal lobe. From there, the axons split to travel to several brain regions. Some travel to the cerebrum, specifically to the primary olfactory cortex that is located in the inferior and medial areas of the temporal lobe. Others project to structures within the limbic system and hypothalamus, where smells become associated with long-term memory and emotional responses. This is how certain smells trigger emotional memories, such as the smell of food associated with one’s birthplace. Smell is the one sensory modality that does not synapse in the thalamus before connecting to the cerebral cortex. This intimate connection between the

olfactory system and the cerebral cortex is one reason why smell can be a potent trigger of memories and emotion.

The nasal epithelium, including the olfactory cells, can be harmed by airborne toxic chemicals. Therefore, the olfactory neurons are regularly replaced within the nasal epithelium, after which the axons of the new neurons must find their appropriate connections in the olfactory bulb. These new axons grow along the axons that are already in place in the cranial nerve.

The Olfactory System



(c) Olfactory epithelium

(a) The olfactory system begins in the peripheral structures of the nasal cavity. (b) The olfactory receptor neurons are within the olfactory epithelium. (c) Axons of the olfactory receptor neurons project through the cribriform plate of the ethmoid bone and synapse with the neurons of the olfactory bulb (tissue source: simian). LM $\times 812$. (Micrograph provided by the Regents of

Note:

Disorders of the...

Olfactory System: Anosmia

Blunt force trauma to the face, such as that common in many car accidents, can lead to the loss of the olfactory nerve, and subsequently, loss of the sense of smell. This condition is known as **anosmia**. When the frontal lobe of the brain moves relative to the ethmoid bone, the olfactory tract axons may be sheared apart. Professional fighters often experience anosmia because of repeated trauma to face and head. In addition, certain pharmaceuticals, such as antibiotics, can cause anosmia by killing all the olfactory neurons at once. If no axons are in place within the olfactory nerve, then the axons from newly formed olfactory neurons have no guide to lead them to their connections within the olfactory bulb. There are temporary causes of anosmia, as well, such as those caused by inflammatory responses related to respiratory infections or allergies.

Loss of the sense of smell can result in food tasting bland. A person with an impaired sense of smell may require additional spice and seasoning levels for food to be tasted. Anosmia may also be related to some presentations of mild depression, because the loss of enjoyment of food may lead to a general sense of despair.

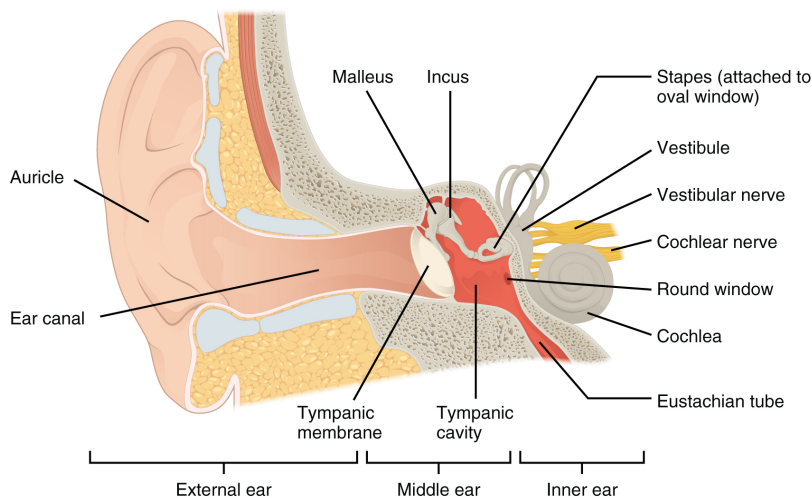
The ability of olfactory neurons to replace themselves decreases with age, leading to age-related anosmia. This explains why some elderly people salt their food more than younger people do. However, this increased sodium intake can increase blood volume and blood pressure, increasing the risk of cardiovascular diseases in the elderly.

Audition (Hearing)

Hearing, or **audition**, is the transduction of sound waves into a neural signal that is made possible by the structures of the ear ([\[link\]](#)). The large, fleshy structure on the lateral aspect of the head is known as the **auricle**. Some

sources will also refer to this structure as the pinna, though that term is more appropriate for a structure that can be moved, such as the external ear of a cat. The C-shaped curves of the auricle direct sound waves toward the auditory canal. The canal enters the skull through the external auditory meatus of the temporal bone. At the end of the auditory canal is the **tympanic membrane**, or ear drum, which vibrates after it is struck by sound waves. The auricle, ear canal, and tympanic membrane are often referred to as the **external ear**. The **middle ear** consists of a space spanned by three small bones called the **ossicles**. The three ossicles are the **malleus**, **incus**, and **stapes**, which are Latin names that roughly translate to hammer, anvil, and stirrup. The malleus is attached to the tympanic membrane and articulates with the incus. The incus, in turn, articulates with the stapes. The stapes is then attached to the **inner ear**, where the sound waves will be transduced into a neural signal. The middle ear is connected to the pharynx through the Eustachian tube, which helps equilibrate air pressure across the tympanic membrane. The tube is normally closed but will pop open when the muscles of the pharynx contract during swallowing or yawning.

Structures of the Ear

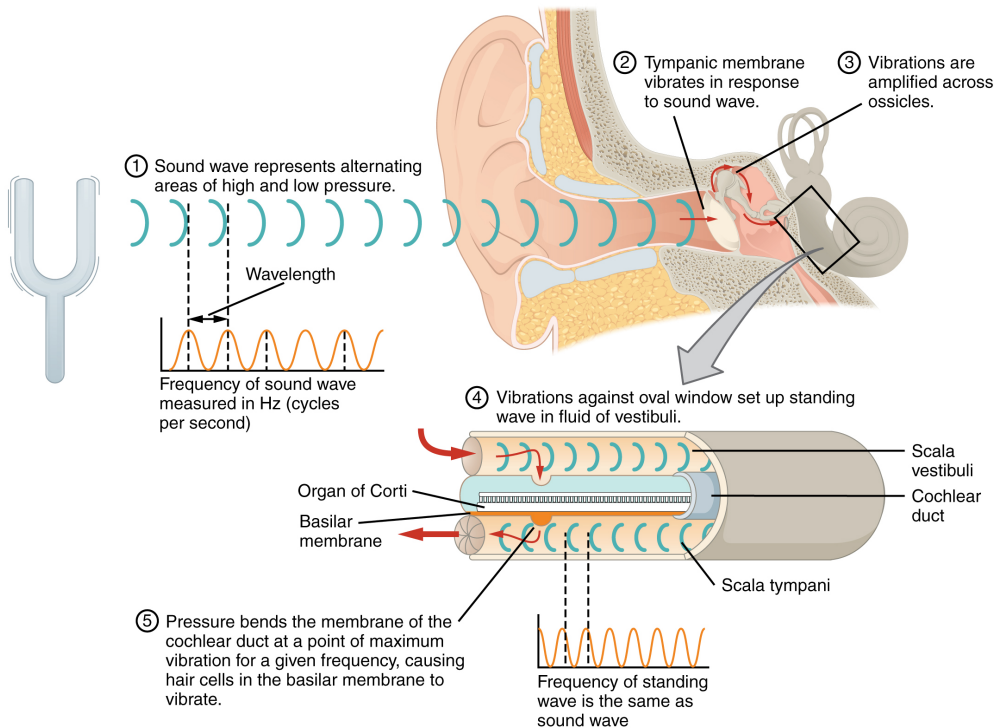


The external ear contains the auricle, ear canal, and tympanic membrane. The middle ear contains the ossicles and is connected to the pharynx by the Eustachian tube. The inner ear contains the cochlea and vestibule, which are responsible for audition and equilibrium, respectively.

The inner ear is often described as a bony labyrinth, as it is composed of a series of canals embedded within the temporal bone. It has two separate regions, the **cochlea** and the **vestibule**, which are responsible for hearing and balance, respectively. The neural signals from these two regions are relayed to the brain stem through separate fiber bundles. However, these two distinct bundles travel together from the inner ear to the brain stem as the vestibulocochlear nerve. Sound is transduced into neural signals within the cochlear region of the inner ear, which contains the sensory neurons of the **spiral ganglia**. These ganglia are located within the spiral-shaped cochlea of the inner ear. The cochlea is attached to the stapes through the **oval window**.

The oval window is located at the beginning of a fluid-filled tube within the cochlea called the **scala vestibuli**. The scala vestibuli extends from the oval window, travelling above the **cochlear duct**, which is the central cavity of the cochlea that contains the sound-transducing neurons. At the uppermost tip of the cochlea, the scala vestibuli curves over the top of the cochlear duct. The fluid-filled tube, now called the **scala tympani**, returns to the base of the cochlea, this time travelling under the cochlear duct. The scala tympani ends at the **round window**, which is covered by a membrane that contains the fluid within the scala. As vibrations of the ossicles travel through the oval window, the fluid of the scala vestibuli and scala tympani moves in a wave-like motion. The frequency of the fluid waves match the frequencies of the sound waves ([\[link\]](#)). The membrane covering the round window will bulge out or pucker in with the movement of the fluid within the scala tympani.

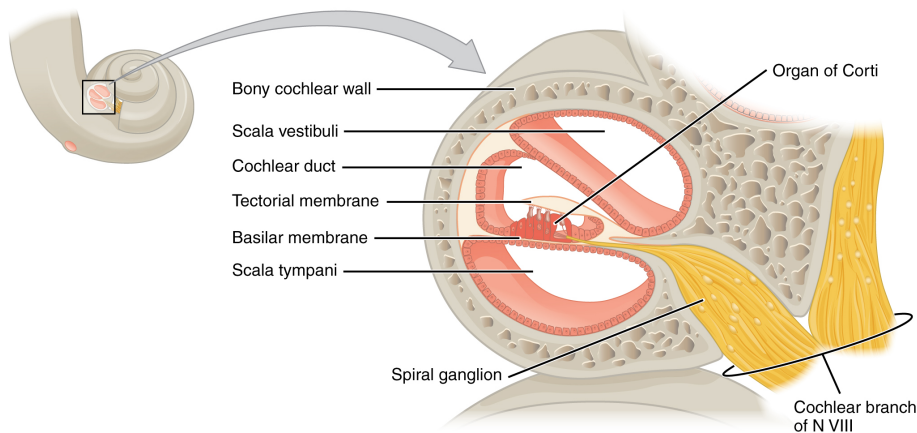
Transmission of Sound Waves to Cochlea



A sound wave causes the tympanic membrane to vibrate. This vibration is amplified as it moves across the malleus, incus, and stapes. The amplified vibration is picked up by the oval window causing pressure waves in the fluid of the scala vestibuli and scala tympani. The complexity of the pressure waves is determined by the changes in amplitude and frequency of the sound waves entering the ear.

A cross-sectional view of the cochlea shows that the scala vestibuli and scala tympani run along both sides of the cochlear duct ([\[link\]](#)). The cochlear duct contains several **organs of Corti**, which transduce the wave motion of the two scala into neural signals. The organs of Corti lie on top of the **basilar membrane**, which is the side of the cochlear duct located between the organs of Corti and the scala tympani. As the fluid waves move through the scala vestibuli and scala tympani, the basilar membrane moves at a specific spot, depending on the frequency of the waves. Higher frequency waves move the region of the basilar membrane that is close to the base of the cochlea. Lower frequency waves move the region of the basilar membrane that is near the tip of the cochlea.

Cross Section of the Cochlea

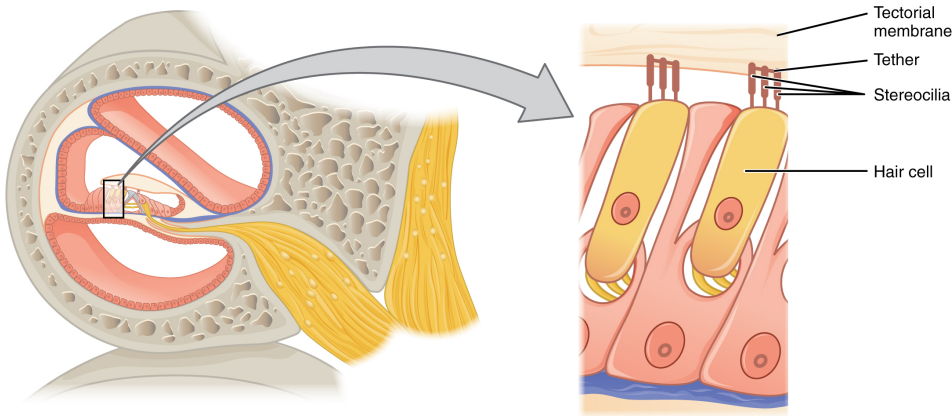


The three major spaces within the cochlea are highlighted. The scala tympani and scala vestibuli lie on either side of the cochlear duct. The organ of Corti, containing the mechanoreceptor hair cells, is adjacent to the scala tympani, where it sits atop the basilar membrane.

The organs of Corti contain **hair cells**, which are named for the hair-like **stereocilia** extending from the cell's apical surfaces ([\[link\]](#)). The stereocilia are an array of microvilli-like structures arranged from tallest to shortest. Protein fibers tether adjacent hairs together within each array, such that the array will bend in response to movements of the basilar membrane. The stereocilia extend up from the hair cells to the overlying **tectorial membrane**, which is attached medially to the organ of Corti. When the pressure waves from the scala move the basilar membrane, the tectorial membrane slides across the stereocilia. This bends the stereocilia either toward or away from the tallest member of each array. When the stereocilia bend toward the tallest member of their array, tension in the protein tethers opens ion channels in the hair cell membrane. This will depolarize the hair cell membrane, triggering nerve impulses that travel down the afferent nerve fibers attached to the hair cells. When the stereocilia bend toward the shortest member of their array, the tension on the tethers slackens and the ion channels close. When no sound is present, and the stereocilia are standing straight, a small amount of tension still

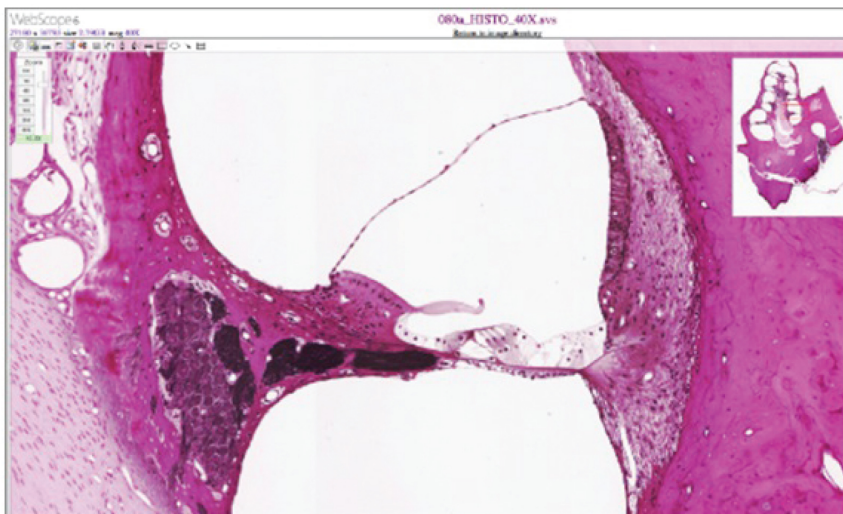
exists on the tethers, keeping the membrane potential of the hair cell slightly depolarized.

Hair Cell



The hair cell is a mechanoreceptor with an array of stereocilia emerging from its apical surface. The stereocilia are tethered together by proteins that open ion channels when the array is bent toward the tallest member of their array, and closed when the array is bent toward the shortest member of their array.

Cochlea and Organ of Corti



LM $\times 412$. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)

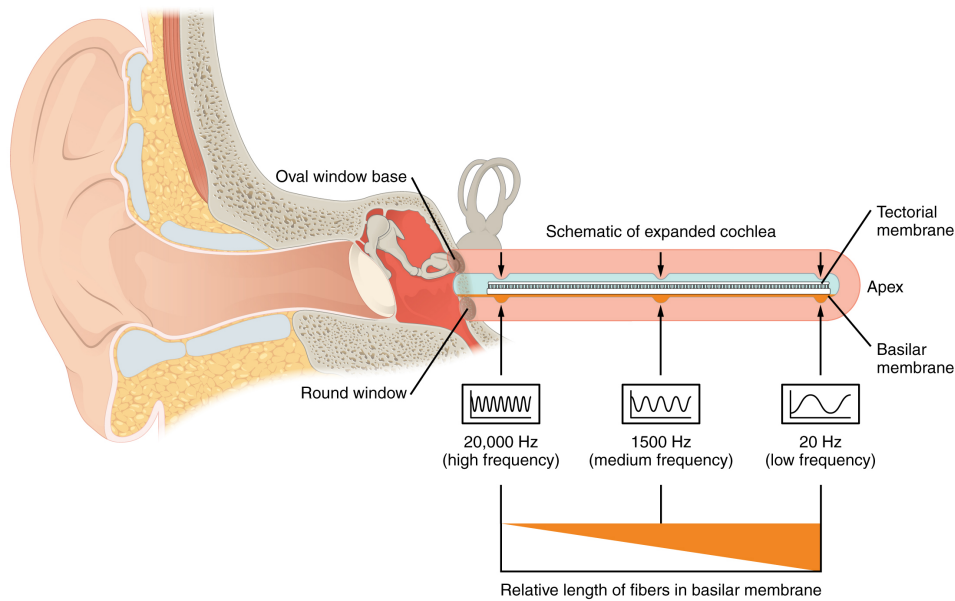
Note:



View the [University of Michigan WebScope](#) to explore the tissue sample in greater detail. The basilar membrane is the thin membrane that extends from the central core of the cochlea to the edge. What is anchored to this membrane so that they can be activated by movement of the fluids within the cochlea?

As stated above, a given region of the basilar membrane will only move if the incoming sound is at a specific frequency. Because the tectorial membrane only moves where the basilar membrane moves, the hair cells in this region will also only respond to sounds of this specific frequency. Therefore, as the frequency of a sound changes, different hair cells are activated all along the basilar membrane. The cochlea encodes auditory stimuli for frequencies between 20 and 20,000 Hz, which is the range of sound that human ears can detect. The unit of Hertz measures the frequency of sound waves in terms of cycles produced per second. Frequencies as low as 20 Hz are detected by hair cells at the apex, or tip, of the cochlea. Frequencies in the higher ranges of 20 KHz are encoded by hair cells at the base of the cochlea, close to the round and oval windows ([link](#)). Most auditory stimuli contain a mixture of sounds at a variety of frequencies and intensities (represented by the amplitude of the sound wave). The hair cells along the length of the cochlear duct, which are each sensitive to a particular frequency, allow the cochlea to separate auditory stimuli by frequency, just as a prism separates visible light into its component colors.

Frequency Coding in the Cochlea



The standing sound wave generated in the cochlea by the movement of the oval window deflects the basilar membrane on the basis of the frequency of sound. Therefore, hair cells at the base of the cochlea are activated only by high frequencies, whereas those at the apex of the cochlea are activated only by low frequencies.

Note:



Watch this [video](#) to learn more about how the structures of the ear convert sound waves into a neural signal by moving the “hairs,” or stereocilia, of the cochlear duct. Specific locations along the length of the duct encode specific frequencies, or pitches. The brain interprets the meaning of the sounds we

hear as music, speech, noise, etc. Which ear structures are responsible for the amplification and transfer of sound from the external ear to the inner ear?

Note:



Watch this [animation](#) to learn more about the inner ear and to see the cochlea unroll, with the base at the back of the image and the apex at the front. Specific wavelengths of sound cause specific regions of the basilar membrane to vibrate, much like the keys of a piano produce sound at different frequencies. Based on the animation, where do frequencies—from high to low pitches—cause activity in the hair cells within the cochlear duct?

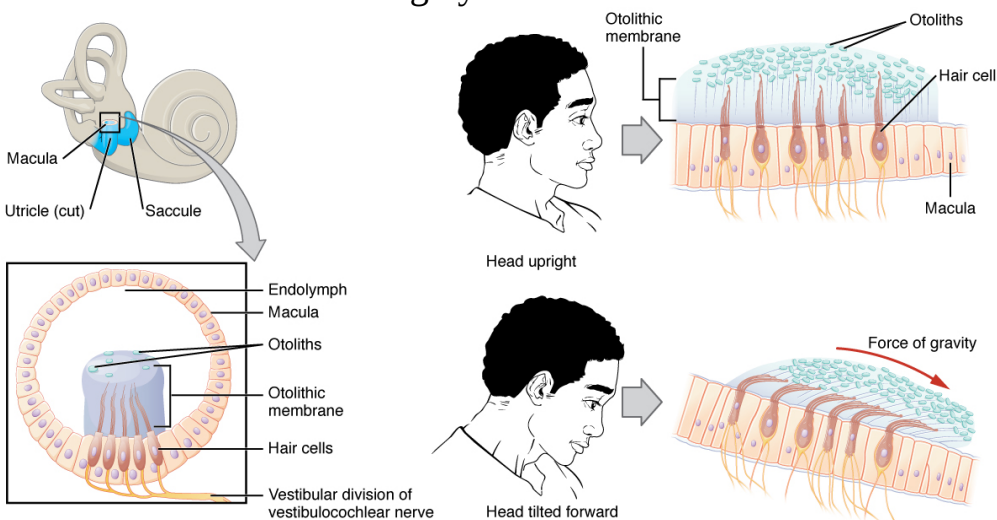
Equilibrium (Balance)

Along with audition, the inner ear is responsible for encoding information about **equilibrium**, the sense of balance. A similar mechanoreceptor—a hair cell with stereocilia—senses head position, head movement, and whether our bodies are in motion. These cells are located within the vestibule of the inner ear. Head position is sensed by the **utricle** and **saccule**, whereas head movement is sensed by the **semicircular canals**. The neural signals generated in the **vestibular ganglion** are transmitted through the vestibulocochlear nerve to the brain stem and cerebellum.

The utricle and saccule are both largely composed of **macula** tissue (plural = maculae). The macula is composed of hair cells surrounded by support cells. The stereocilia of the hair cells extend into a viscous gel called the **otolithic membrane** ([link](#)). On top of the otolithic membrane is a layer of calcium carbonate crystals, called otoliths. The otoliths essentially make the otolithic membrane top-heavy. The otolithic membrane moves separately from the

macula in response to head movements. Tilting the head causes the otolithic membrane to slide over the macula in the direction of gravity. The moving otolithic membrane, in turn, bends the stereocilia, causing some hair cells to depolarize as others hyperpolarize. The exact position of the head is interpreted by the brain based on the pattern of hair-cell depolarization.

Linear Acceleration Coding by Maculae

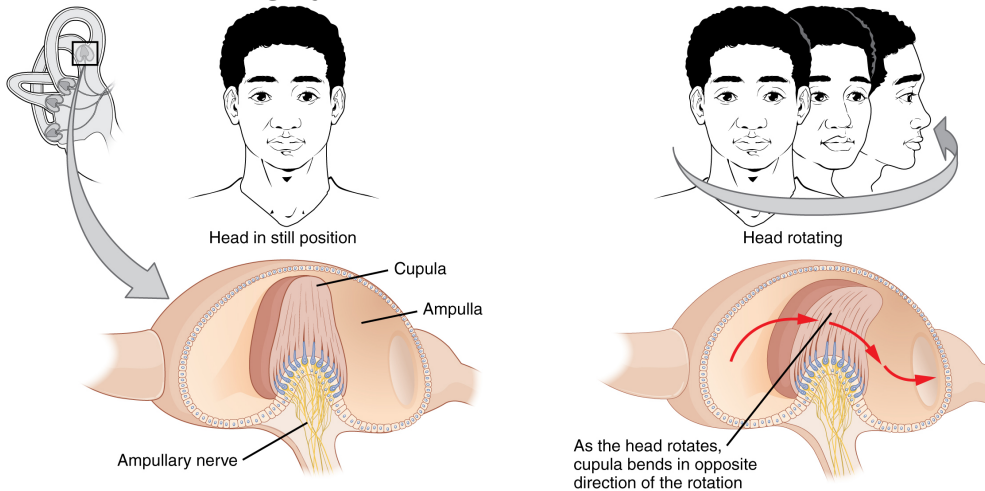


The maculae are specialized for sensing linear acceleration, such as when gravity acts on the tilting head, or if the head starts moving in a straight line. The difference in inertia between the hair cell stereocilia and the otolithic membrane in which they are embedded leads to a shearing force that causes the stereocilia to bend in the direction of that linear acceleration.

The semicircular canals are three ring-like extensions of the vestibule. One is oriented in the horizontal plane, whereas the other two are oriented in the vertical plane. The anterior and posterior vertical canals are oriented at approximately 45 degrees relative to the sagittal plane ([\[link\]](#)). The base of each semicircular canal, where it meets with the vestibule, connects to an enlarged region known as the **ampulla**. The ampulla contains the hair cells that respond to rotational movement, such as turning the head while saying “no.” The stereocilia of these hair cells extend into the **cupula**, a membrane that attaches to the top of the ampulla. As the head rotates in a plane parallel to the semicircular canal, the fluid lags, deflecting the cupula in the direction

opposite to the head movement. The semicircular canals contain several ampullae, with some oriented horizontally and others oriented vertically. By comparing the relative movements of both the horizontal and vertical ampullae, the vestibular system can detect the direction of most head movements within three-dimensional (3-D) space.

Rotational Coding by Semicircular Canals



Rotational movement of the head is encoded by the hair cells in the base of the semicircular canals. As one of the canals moves in an arc with the head, the internal fluid moves in the opposite direction, causing the cupula and stereocilia to bend. The movement of two canals within a plane results in information about the direction in which the head is moving, and activation of all six canals can give a very precise indication of head movement in three dimensions.

Somatosensation (Touch)

Somatosensation is considered a general sense, as opposed to the special senses discussed in this section. Somatosensation is the group of sensory modalities that are associated with touch, proprioception, and interoception. These modalities include pressure, vibration, light touch, tickle, itch, temperature, pain, proprioception, and kinesthesia. This means that its receptors are not

associated with a specialized organ, but are instead spread throughout the body in a variety of organs. Many of the somatosensory receptors are located in the skin, but receptors are also found in muscles, tendons, joint capsules, ligaments, and in the walls of visceral organs.

Two types of somatosensory signals that are transduced by free nerve endings are pain and temperature. These two modalities use thermoreceptors and nociceptors to transduce temperature and pain stimuli, respectively.

Temperature receptors are stimulated when local temperatures differ from body temperature. Some thermoreceptors are sensitive to just cold and others to just heat. Nociception is the sensation of potentially damaging stimuli. Mechanical, chemical, or thermal stimuli beyond a set threshold will elicit painful sensations. Stressed or damaged tissues release chemicals that activate receptor proteins in the nociceptors. For example, the sensation of heat associated with spicy foods involves **capsaicin**, the active molecule in hot peppers. Capsaicin molecules bind to a transmembrane ion channel in nociceptors that is sensitive to temperatures above 37°C. The dynamics of capsaicin binding with this transmembrane ion channel is unusual in that the molecule remains bound for a long time. Because of this, it will decrease the ability of other stimuli to elicit pain sensations through the activated nociceptor. For this reason, capsaicin can be used as a topical analgesic, such as in products such as Icy Hot™.

If you drag your finger across a textured surface, the skin of your finger will vibrate. Such low frequency vibrations are sensed by mechanoreceptors called Merkel cells, also known as type I cutaneous mechanoreceptors. Merkel cells are located in the stratum basale of the epidermis. Deep pressure and vibration is transduced by lamellated (Pacinian) corpuscles, which are receptors with encapsulated endings found deep in the dermis, or subcutaneous tissue. Light touch is transduced by the encapsulated endings known as tactile (Meissner) corpuscles. Follicles are also wrapped in a plexus of nerve endings known as the hair follicle plexus. These nerve endings detect the movement of hair at the surface of the skin, such as when an insect may be walking along the skin. Stretching of the skin is transduced by stretch receptors known as bulbous corpuscles. Bulbous corpuscles are also known as Ruffini corpuscles, or type II cutaneous mechanoreceptors.

Other somatosensory receptors are found in the joints and muscles. Stretch receptors monitor the stretching of tendons, muscles, and the components of joints. For example, have you ever stretched your muscles before or after

exercise and noticed that you can only stretch so far before your muscles spasm back to a less stretched state? This spasm is a reflex that is initiated by stretch receptors to avoid muscle tearing. Such stretch receptors can also prevent over-contraction of a muscle. In skeletal muscle tissue, these stretch receptors are called muscle spindles. Golgi tendon organs similarly transduce the stretch levels of tendons. Bulbous corpuscles are also present in joint capsules, where they measure stretch in the components of the skeletal system within the joint. The types of nerve endings, their locations, and the stimuli they transduce are presented in [\[link\]](#).

Mechanoreceptors of Somatosensation			
Name	Historical (eponymous) name	Location(s)	Stimuli
Free nerve endings	*	Dermis, cornea, tongue, joint capsules, visceral organs	Pain, temperature, mechanical deformation
Mechanoreceptors	Merkel's discs	Epidermal–dermal junction, mucosal membranes	Low frequency vibration (5–15 Hz)
Bulbous corpuscle	Ruffini's corpuscle	Dermis, joint capsules	Stretch

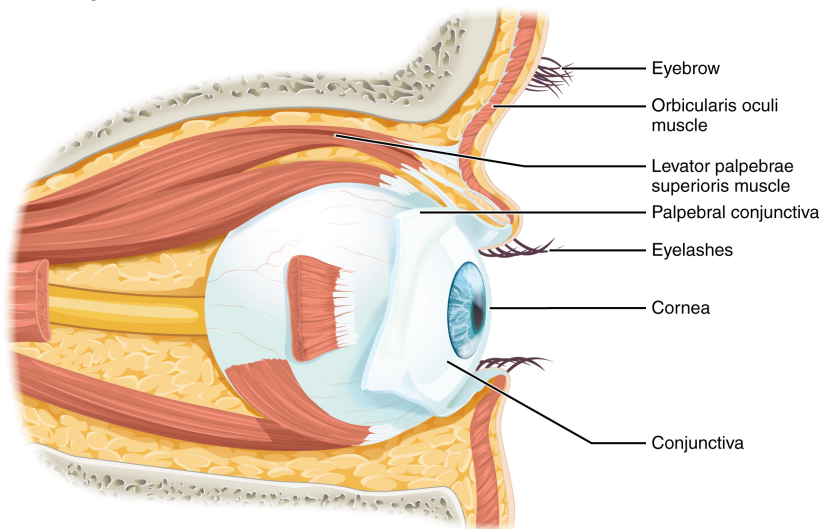
Mechanoreceptors of Somatosensation			
Name	Historical (eponymous) name	Location(s)	Stimuli
Tactile corpuscle	Meissner's corpuscle	Papillary dermis, especially in the fingertips and lips	Light touch, vibrations below 50 Hz
Lamellated corpuscle	Pacinian corpuscle	Deep dermis, subcutaneous tissue	Deep pressure, high-frequency vibration (around 250 Hz)
Hair follicle plexus	*	Wrapped around hair follicles in the dermis	Movement of hair
Muscle spindle	*	In line with skeletal muscle fibers	Muscle contraction and stretch
Tendon stretch organ	Golgi tendon organ	In line with tendons	Stretch of tendons

*No corresponding eponymous name.

Vision

Vision is the special sense of sight that is based on the transduction of light stimuli received through the eyes. The eyes are located within either orbit in the skull. The bony orbits surround the eyeballs, protecting them and anchoring the soft tissues of the eye ([\[link\]](#)). The eyelids, with lashes at their leading edges, help to protect the eye from abrasions by blocking particles that may land on the surface of the eye. The inner surface of each lid is a thin membrane known as the **palpebral conjunctiva**. The conjunctiva extends over the white areas of the eye (the sclera), connecting the eyelids to the eyeball. Tears are produced by the **lacrimal gland**, located beneath the lateral edges of the nose. Tears produced by this gland flow through the **lacrimal duct** to the medial corner of the eye, where the tears flow over the conjunctiva, washing away foreign particles.

The Eye in the Orbit



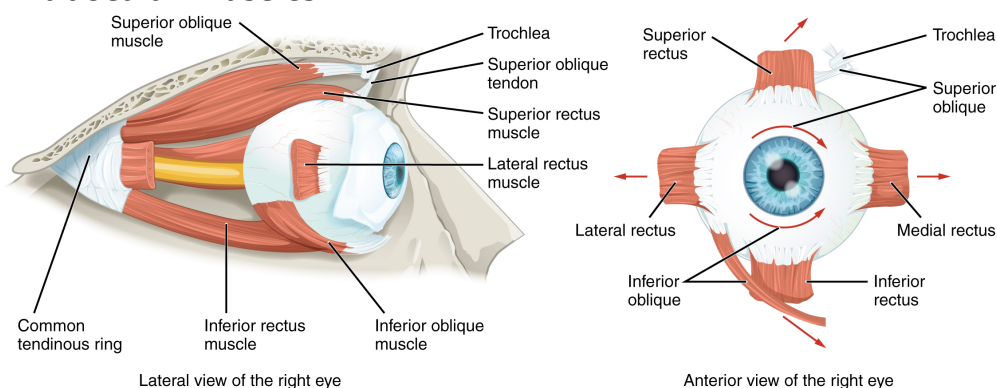
The eye is located within the orbit and surrounded by soft tissues that protect and support its function. The orbit is surrounded by cranial bones of the skull.

Movement of the eye within the orbit is accomplished by the contraction of six **extraocular muscles** that originate from the bones of the orbit and insert into the surface of the eyeball ([\[link\]](#)). Four of the muscles are arranged at the cardinal points around the eye and are named for those locations. They are the **superior rectus**, **medial rectus**, **inferior rectus**, and **lateral rectus**. When

each of these muscles contract, the eye moves toward the contracting muscle. For example, when the superior rectus contracts, the eye rotates to look up. The **superior oblique** originates at the posterior orbit, near the origin of the four rectus muscles. However, the tendon of the oblique muscles threads through a pulley-like piece of cartilage known as the **trochlea**. The tendon inserts obliquely into the superior surface of the eye. The angle of the tendon through the trochlea means that contraction of the superior oblique rotates the eye medially. The **inferior oblique** muscle originates from the floor of the orbit and inserts into the inferolateral surface of the eye. When it contracts, it laterally rotates the eye, in opposition to the superior oblique. Rotation of the eye by the two oblique muscles is necessary because the eye is not perfectly aligned on the sagittal plane. When the eye looks up or down, the eye must also rotate slightly to compensate for the superior rectus pulling at approximately a 20-degree angle, rather than straight up. The same is true for the inferior rectus, which is compensated by contraction of the inferior oblique. A seventh muscle in the orbit is the **levator palpebrae superioris**, which is responsible for elevating and retracting the upper eyelid, a movement that usually occurs in concert with elevation of the eye by the superior rectus (see [\[link\]](#)).

The extraocular muscles are innervated by three cranial nerves. The lateral rectus, which causes abduction of the eye, is innervated by the abducens nerve. The superior oblique is innervated by the trochlear nerve. All of the other muscles are innervated by the oculomotor nerve, as is the levator palpebrae superioris. The motor nuclei of these cranial nerves connect to the brain stem, which coordinates eye movements.

Extraocular Muscles



The extraocular muscles move the eye within the orbit.

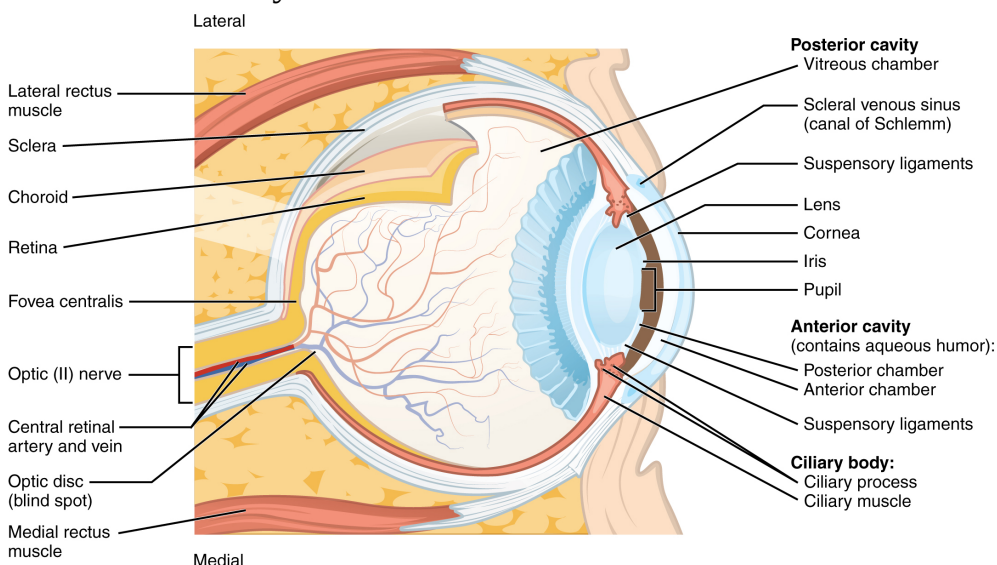
The eye itself is a hollow sphere composed of three layers of tissue. The outermost layer is the **fibrous tunic**, which includes the white **sclera** and clear **cornea**. The sclera accounts for five sixths of the surface of the eye, most of which is not visible, though humans are unique compared with many other species in having so much of the “white of the eye” visible ([\[link\]](#)). The transparent cornea covers the anterior tip of the eye and allows light to enter the eye. The middle layer of the eye is the **vascular tunic**, which is mostly composed of the choroid, ciliary body, and iris. The **choroid** is a layer of highly vascularized connective tissue that provides a blood supply to the eyeball. The choroid is posterior to the **ciliary body**, a muscular structure that is attached to the **lens** by suspensory ligaments, or **zonule fibers**. These two structures bend the lens, allowing it to focus light on the back of the eye. Overlaying the ciliary body, and visible in the anterior eye, is the **iris**—the colored part of the eye. The iris is a smooth muscle that opens or closes the **pupil**, which is the hole at the center of the eye that allows light to enter. The iris constricts the pupil in response to bright light and dilates the pupil in response to dim light. The innermost layer of the eye is the **neural tunic**, or **retina**, which contains the nervous tissue responsible for photoreception.

The eye is also divided into two cavities: the anterior cavity and the posterior cavity. The anterior cavity is the space between the cornea and lens, including the iris and ciliary body. It is filled with a watery fluid called the **aqueous humor**. The posterior cavity is the space behind the lens that extends to the posterior side of the interior eyeball, where the retina is located. The posterior cavity is filled with a more viscous fluid called the **vitreous humor**.

The retina is composed of several layers and contains specialized cells for the initial processing of visual stimuli. The photoreceptors (rods and cones) change their membrane potential when stimulated by light energy. The change in membrane potential alters the amount of neurotransmitter that the photoreceptor cells release onto **bipolar cells** in the **outer synaptic layer**. It is the bipolar cell in the retina that connects a photoreceptor to a **retinal ganglion cell (RGC)** in the **inner synaptic layer**. There, **amacrine cells** additionally contribute to retinal processing before an action potential is produced by the RGC. The axons of RGCs, which lie at the innermost layer of the retina, collect at the **optic disc** and leave the eye as the **optic nerve** (see [\[link\]](#)). Because these axons pass through the retina, there are no photoreceptors at the

very back of the eye, where the optic nerve begins. This creates a “blind spot” in the retina, and a corresponding blind spot in our visual field.

Structure of the Eye



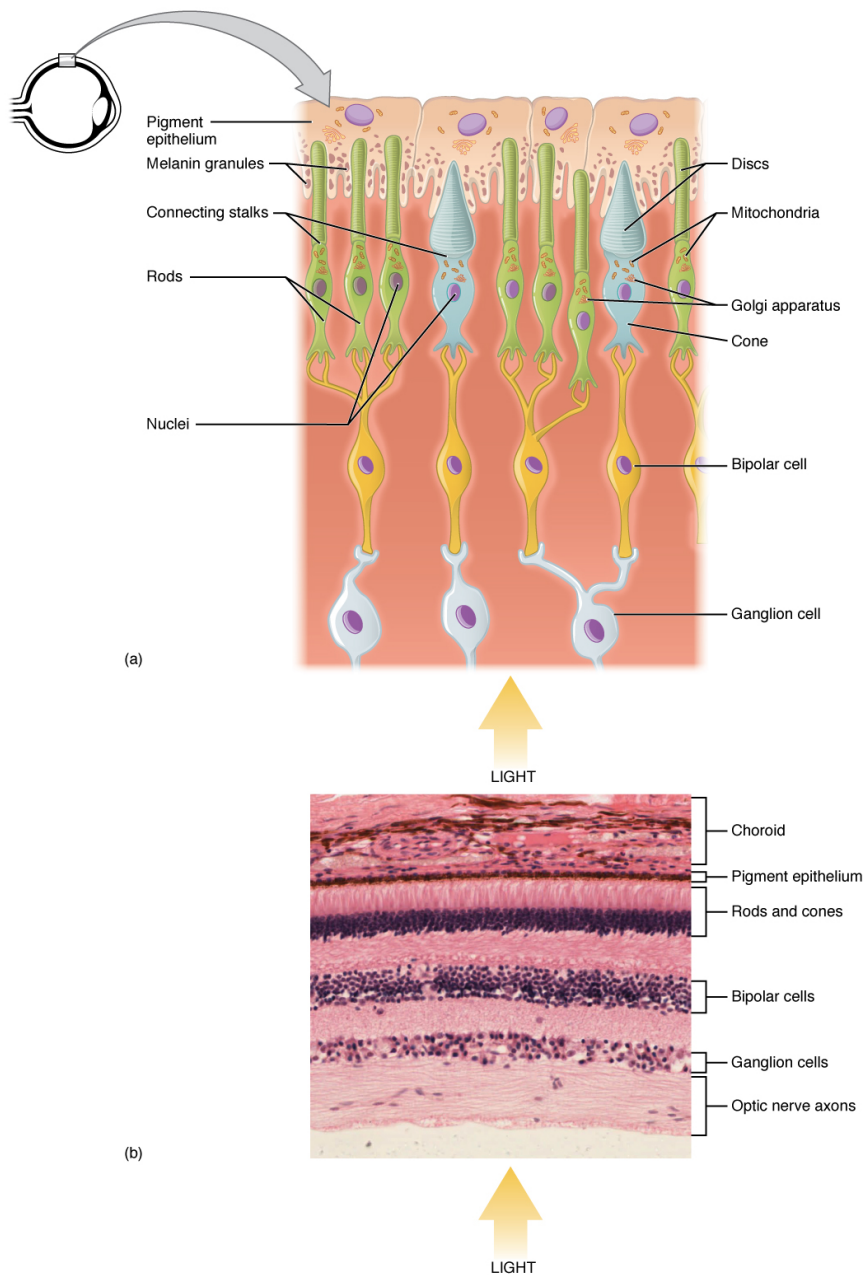
The sphere of the eye can be divided into anterior and posterior chambers. The wall of the eye is composed of three layers: the fibrous tunic, vascular tunic, and neural tunic. Within the neural tunic is the retina, with three layers of cells and two synaptic layers in between. The center of the retina has a small indentation known as the fovea.

Note that the photoreceptors in the retina (rods and cones) are located behind the axons, RGCs, bipolar cells, and retinal blood vessels. A significant amount of light is absorbed by these structures before the light reaches the photoreceptor cells. However, at the exact center of the retina is a small area known as the **fovea**. At the fovea, the retina lacks the supporting cells and blood vessels, and only contains photoreceptors. Therefore, **visual acuity**, or the sharpness of vision, is greatest at the fovea. This is because the fovea is where the least amount of incoming light is absorbed by other retinal structures (see [\[link\]](#)). As one moves in either direction from this central point of the retina, visual acuity drops significantly. In addition, each photoreceptor cell of the fovea is connected to a single RGC. Therefore, this RGC does not have to integrate inputs from multiple photoreceptors, which reduces the accuracy of visual transduction. Toward the edges of the retina, several photoreceptors

converge on RGCs (through the bipolar cells) up to a ratio of 50 to 1. The difference in visual acuity between the fovea and peripheral retina is easily evidenced by looking directly at a word in the middle of this paragraph. The visual stimulus in the middle of the field of view falls on the fovea and is in the sharpest focus. Without moving your eyes off that word, notice that words at the beginning or end of the paragraph are not in focus. The images in your peripheral vision are focused by the peripheral retina, and have vague, blurry edges and words that are not as clearly identified. As a result, a large part of the neural function of the eyes is concerned with moving the eyes and head so that important visual stimuli are centered on the fovea.

Light falling on the retina causes chemical changes to pigment molecules in the photoreceptors, ultimately leading to a change in the activity of the RGCs. Photoreceptor cells have two parts, the **inner segment** and the **outer segment** ([link](#)). The inner segment contains the nucleus and other common organelles of a cell, whereas the outer segment is a specialized region in which photoreception takes place. There are two types of photoreceptors—rods and cones—which differ in the shape of their outer segment. The rod-shaped outer segments of the **rod photoreceptor** contain a stack of membrane-bound discs that contain the photosensitive pigment **rhodopsin**. The cone-shaped outer segments of the **cone photoreceptor** contain their photosensitive pigments in infoldings of the cell membrane. There are three cone photopigments, called **opsins**, which are each sensitive to a particular wavelength of light. The wavelength of visible light determines its color. The pigments in human eyes are specialized in perceiving three different primary colors: red, green, and blue.

Photoreceptor



(a) All photoreceptors have inner segments containing the nucleus and other important organelles and outer segments with membrane arrays containing the photosensitive opsin molecules. Rod outer segments are long columnar shapes with stacks of membrane-bound discs that contain the rhodopsin pigment. Cone outer segments are short, tapered shapes with folds of membrane in place of the discs in the rods. (b)

Tissue of the retina shows a dense layer of nuclei of the rods and cones. LM \times 800. (Micrograph provided by the Regents of University of Michigan Medical School © 2012)

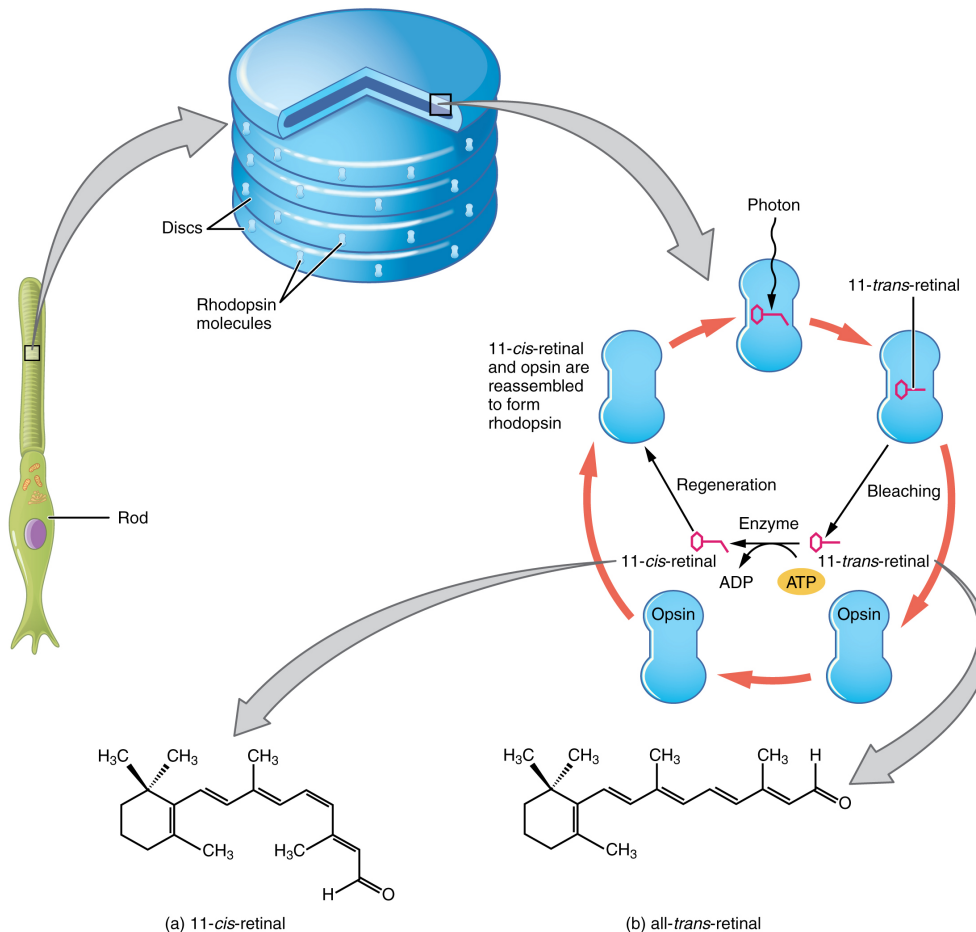
At the molecular level, visual stimuli cause changes in the photopigment molecule that lead to changes in membrane potential of the photoreceptor cell. A single unit of light is called a **photon**, which is described in physics as a packet of energy with properties of both a particle and a wave. The energy of a photon is represented by its wavelength, with each wavelength of visible light corresponding to a particular color. Visible light is electromagnetic radiation with a wavelength between 380 and 720 nm. Wavelengths of electromagnetic radiation longer than 720 nm fall into the infrared range, whereas wavelengths shorter than 380 nm fall into the ultraviolet range. Light with a wavelength of 380 nm is blue whereas light with a wavelength of 720 nm is dark red. All other colors fall between red and blue at various points along the wavelength scale.

Opsin pigments are actually transmembrane proteins that contain a cofactor known as **retinal**. Retinal is a hydrocarbon molecule related to vitamin A. When a photon hits retinal, the long hydrocarbon chain of the molecule is biochemically altered. Specifically, photons cause some of the double-bonded carbons within the chain to switch from a *cis* to a *trans* conformation. This process is called **photoisomerization**. Before interacting with a photon, retinal's flexible double-bonded carbons are in the *cis* conformation. This molecule is referred to as 11-*cis*-retinal. A photon interacting with the molecule causes the flexible double-bonded carbons to change to the *trans*-conformation, forming all-*trans*-retinal, which has a straight hydrocarbon chain ([link](#)).

The shape change of retinal in the photoreceptors initiates visual transduction in the retina. Activation of retinal and the opsin proteins result in activation of a G protein. The G protein changes the membrane potential of the photoreceptor cell, which then releases less neurotransmitter into the outer synaptic layer of the retina. Until the retinal molecule is changed back to the 11-*cis*-retinal shape, the opsin cannot respond to light energy, which is called bleaching. When a large group of photopigments is bleached, the retina will

send information as if opposing visual information is being perceived. After a bright flash of light, afterimages are usually seen in negative. The photoisomerization is reversed by a series of enzymatic changes so that the retinal responds to more light energy.

Retinal Isomers



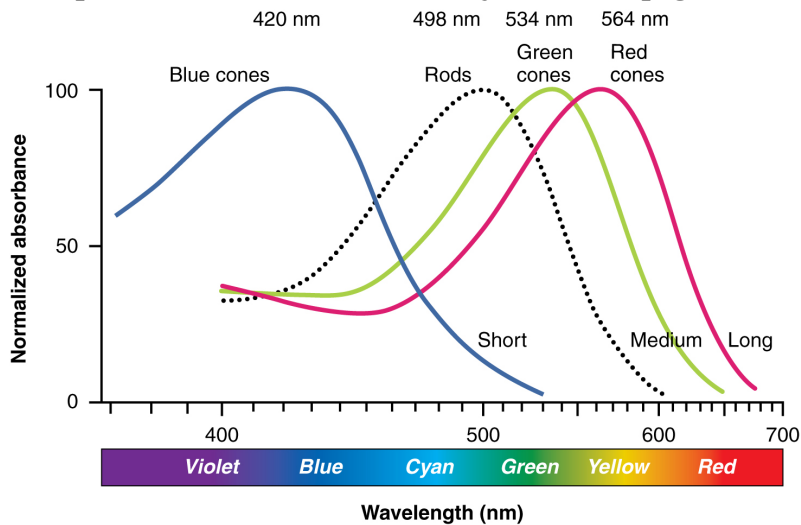
The retinal molecule has two isomers, (a) one before a photon interacts with it and (b) one that is altered through photoisomerization.

The opsins are sensitive to limited wavelengths of light. Rhodopsin, the photopigment in rods, is most sensitive to light at a wavelength of 498 nm. The three color opsins have peak sensitivities of 564 nm, 534 nm, and 420 nm corresponding roughly to the primary colors of red, green, and blue ([link](#)). The absorbance of rhodopsin in the rods is much more sensitive than in the

cone opsins; specifically, rods are sensitive to vision in low light conditions, and cones are sensitive to brighter conditions. In normal sunlight, rhodopsin will be constantly bleached while the cones are active. In a darkened room, there is not enough light to activate cone opsins, and vision is entirely dependent on rods. Rods are so sensitive to light that a single photon can result in an action potential from a rod's corresponding RGC.

The three types of cone opsins, being sensitive to different wavelengths of light, provide us with color vision. By comparing the activity of the three different cones, the brain can extract color information from visual stimuli. For example, a bright blue light that has a wavelength of approximately 450 nm would activate the “red” cones minimally, the “green” cones marginally, and the “blue” cones predominantly. The relative activation of the three different cones is calculated by the brain, which perceives the color as blue. However, cones cannot react to low-intensity light, and rods do not sense the color of light. Therefore, our low-light vision is—in essence—in grayscale. In other words, in a dark room, everything appears as a shade of gray. If you think that you can see colors in the dark, it is most likely because your brain knows what color something is and is relying on that memory.

Comparison of Color Sensitivity of Photopigments



Comparing the peak sensitivity and absorbance spectra of the four photopigments suggests that they are most sensitive to particular wavelengths.

Note:



Watch this [video](#) to learn more about a transverse section through the brain that depicts the visual pathway from the eye to the occipital cortex. The first half of the pathway is the projection from the RGCs through the optic nerve to the lateral geniculate nucleus in the thalamus on either side. This first fiber in the pathway synapses on a thalamic cell that then projects to the visual cortex in the occipital lobe where “seeing,” or visual perception, takes place. This video gives an abbreviated overview of the visual system by concentrating on the pathway from the eyes to the occipital lobe. The video makes the statement (at 0:45) that “specialized cells in the retina called ganglion cells convert the light rays into electrical signals.” What aspect of retinal processing is simplified by that statement? Explain your answer.

Sensory Nerves

Once any sensory cell transduces a stimulus into a nerve impulse, that impulse has to travel along axons to reach the CNS. In many of the special senses, the axons leaving the sensory receptors have a **topographical** arrangement, meaning that the location of the sensory receptor relates to the location of the axon in the nerve. For example, in the retina, axons from RGCs in the fovea are located at the center of the optic nerve, where they are surrounded by axons from the more peripheral RGCs.

Spinal Nerves

Generally, spinal nerves contain afferent axons from sensory receptors in the periphery, such as from the skin, mixed with efferent axons travelling to the muscles or other effector organs. As the spinal nerve nears the spinal cord, it

splits into dorsal and ventral roots. The dorsal root contains only the axons of sensory neurons, whereas the ventral roots contain only the axons of the motor neurons. Some of the branches will synapse with local neurons in the dorsal root ganglion, posterior (dorsal) horn, or even the anterior (ventral) horn, at the level of the spinal cord where they enter. Other branches will travel a short distance up or down the spine to interact with neurons at other levels of the spinal cord. A branch may also turn into the posterior (dorsal) column of the white matter to connect with the brain. For the sake of convenience, we will use the terms ventral and dorsal in reference to structures within the spinal cord that are part of these pathways. This will help to underscore the relationships between the different components. Typically, spinal nerve systems that connect to the brain are **contralateral**, in that the right side of the body is connected to the left side of the brain and the left side of the body to the right side of the brain.

Cranial Nerves

Cranial nerves convey specific sensory information from the head and neck directly to the brain. For sensations below the neck, the right side of the body is connected to the left side of the brain and the left side of the body to the right side of the brain. Whereas spinal information is contralateral, cranial nerve systems are mostly **ipsilateral**, meaning that a cranial nerve on the right side of the head is connected to the right side of the brain. Some cranial nerves contain only sensory axons, such as the olfactory, optic, and vestibulocochlear nerves. Other cranial nerves contain both sensory and motor axons, including the trigeminal, facial, glossopharyngeal, and vagus nerves (however, the vagus nerve is not associated with the somatic nervous system). The general senses of somatosensation for the face travel through the trigeminal system.

Chapter Review

The senses are olfaction (smell), gustation (taste), somatosensation (sensations associated with the skin and body), audition (hearing), equilibrium (balance), and vision. With the exception of somatosensation, this list represents the special senses, or those systems of the body that are associated with specific organs such as the tongue or eye. Somatosensation belongs to the general senses, which are those sensory structures that are distributed throughout the

body and in the walls of various organs. The special senses are all primarily part of the somatic nervous system in that they are consciously perceived through cerebral processes, though some special senses contribute to autonomic function. The general senses can be divided into somatosensation, which is commonly considered touch, but includes tactile, pressure, vibration, temperature, and pain perception. The general senses also include the visceral senses, which are separate from the somatic nervous system function in that they do not normally rise to the level of conscious perception.

The cells that transduce sensory stimuli into the electrochemical signals of the nervous system are classified on the basis of structural or functional aspects of the cells. The structural classifications are either based on the anatomy of the cell that is interacting with the stimulus (free nerve endings, encapsulated endings, or specialized receptor cell), or where the cell is located relative to the stimulus (interoceptor, exteroceptor, proprioceptor). Thirdly, the functional classification is based on how the cell transduces the stimulus into a neural signal. Chemoreceptors respond to chemical stimuli and are the basis for olfaction and gustation. Related to chemoreceptors are osmoreceptors and nociceptors for fluid balance and pain reception, respectively. Mechanoreceptors respond to mechanical stimuli and are the basis for most aspects of somatosensation, as well as being the basis of audition and equilibrium in the inner ear. Thermoreceptors are sensitive to temperature changes, and photoreceptors are sensitive to light energy.

The nerves that convey sensory information from the periphery to the CNS are either spinal nerves, connected to the spinal cord, or cranial nerves, connected to the brain. Spinal nerves have mixed populations of fibers; some are motor fibers and some are sensory. The sensory fibers connect to the spinal cord through the dorsal root, which is attached to the dorsal root ganglion. Sensory information from the body that is conveyed through spinal nerves will project to the opposite side of the brain to be processed by the cerebral cortex. The cranial nerves can be strictly sensory fibers, such as the olfactory, optic, and vestibulocochlear nerves, or mixed sensory and motor nerves, such as the trigeminal, facial, glossopharyngeal, and vagus nerves. The cranial nerves are connected to the same side of the brain from which the sensory information originates.

Interactive Link Questions

Exercise:**Problem:**

Watch this [video](#) to learn about Dr. Danielle Reed of the Monell Chemical Senses Center in Philadelphia, PA, who became interested in science at an early age because of her sensory experiences. She recognized that her sense of taste was unique compared with other people she knew. Now, she studies the genetic differences between people and their sensitivities to taste stimuli. In the video, there is a brief image of a person sticking out their tongue, which has been covered with a colored dye. This is how Dr. Reed is able to visualize and count papillae on the surface of the tongue. People fall into two large groups known as “tasters” and “non-tasters” on the basis of the density of papillae on their tongue, which also indicates the number of taste buds. Non-tasters can taste food, but they are not as sensitive to certain tastes, such as bitterness. Dr. Reed discovered that she is a non-taster, which explains why she perceived bitterness differently than other people she knew. Are you very sensitive to tastes? Can you see any similarities among the members of your family?

Solution:

Answers will vary, but a typical answer might be: I can eat most anything (except mushrooms!), so I don't think that I'm that sensitive to tastes. My whole family likes eating a variety of foods, so it seems that we all have the same level of sensitivity.

Exercise:**Problem:**

[\[link\]](#) The basilar membrane is the thin membrane that extends from the central core of the cochlea to the edge. What is anchored to this membrane so that they can be activated by movement of the fluids within the cochlea?

Solution:

[\[link\]](#) The hair cells are located in the organ of Corti, which is located on the basilar membrane. The stereocilia of those cells would normally be

attached to the tectorial membrane (though they are detached in the micrograph because of processing of the tissue).

Exercise:

Problem:

Watch this [video](#) to learn more about how the structures of the ear convert sound waves into a neural signal by moving the “hairs,” or stereocilia, of the cochlear duct. Specific locations along the length of the duct encode specific frequencies, or pitches. The brain interprets the meaning of the sounds we hear as music, speech, noise, etc. Which ear structures are responsible for the amplification and transfer of sound from the external ear to the inner ear?

Solution:

The small bones in the middle ear, the ossicles, amplify and transfer sound between the tympanic membrane of the external ear and the oval window of the inner ear.

Exercise:

Problem:

Watch this [animation](#) to learn more about the inner ear and to see the cochlea unroll, with the base at the back of the image and the apex at the front. Specific wavelengths of sound cause specific regions of the basilar membrane to vibrate, much like the keys of a piano produce sound at different frequencies. Based on the animation, where do frequencies—from high to low pitches—cause activity in the hair cells within the cochlear duct?

Solution:

High frequencies activate hair cells toward the base of the cochlea, and low frequencies activate hair cells toward the apex of the cochlea.

Exercise:

Problem:

Watch this [video](#) to learn more about a transverse section through the brain that depicts the visual pathway from the eye to the occipital cortex. The first half of the pathway is the projection from the RGCs through the optic nerve to the lateral geniculate nucleus in the thalamus on either side. This first fiber in the pathway synapses on a thalamic cell that then projects to the visual cortex in the occipital lobe where “seeing,” or visual perception, takes place. This video gives an abbreviated overview of the visual system by concentrating on the pathway from the eyes to the occipital lobe. The video makes the statement (at 0:45) that “specialized cells in the retina called ganglion cells convert the light rays into electrical signals.” What aspect of retinal processing is simplified by that statement? Explain your answer.

Solution:

Photoreceptors convert light energy, or photons, into an electrochemical signal. The retina contains bipolar cells and the RGCs that finally convert it into action potentials that are sent from the retina to the CNS. It is important to recognize when popular media and online sources oversimplify complex physiological processes so that misunderstandings are not generated. This video was created by a medical device manufacturer who might be trying to highlight other aspects of the visual system than retinal processing. The statement they make is not incorrect, it just bundles together several steps, which makes it sound like RGCs are the transducers, rather than photoreceptors.

Review Questions**Exercise:****Problem:**

What type of receptor cell is responsible for transducing pain stimuli?

- a. mechanoreceptor
- b. nociceptor
- c. osmoreceptor

d. photoreceptor

Solution:

B

Exercise:

Problem: Which of these cranial nerves is part of the gustatory system?

- a. olfactory
 - b. trochlear
 - c. trigeminal
 - d. facial
-

Solution:

D

Exercise:

Problem: Which submodality of taste is sensitive to the pH of saliva?

- a. umami
 - b. sour
 - c. bitter
 - d. sweet
-

Solution:

B

Exercise:

Problem: Axons from which neuron in the retina make up the optic nerve?

- a. amacrine cells
- b. photoreceptors

- c. bipolar cells
- d. retinal ganglion cells

Solution:

D

Exercise:

Problem:

What type of receptor cell is involved in the sensations of sound and balance?

- a. photoreceptor
- b. chemoreceptor
- c. mechanoreceptor
- d. nociceptor

Solution:

C

Critical Thinking Questions

Exercise:

Problem:

The sweetener known as stevia can replace glucose in food. What does the molecular similarity of stevia to glucose mean for the gustatory sense?

Solution:

The stevia molecule is similar to glucose such that it will bind to the glucose receptor in sweet-sensitive taste buds. However, it is not a substrate for the ATP-generating metabolism within cells.

Exercise:

Problem:

Why does the blind spot from the optic disc in either eye not result in a blind spot in the visual field?

Solution:

The visual field for each eye is projected onto the retina as light is focused by the lens. The visual information from the right visual field falls on the left side of the retina and vice versa. The optic disc in the right eye is on the medial side of the fovea, which would be the left side of the retina. However, the optic disc in the left eye would be on the right side of that fovea, so the right visual field falls on the side of the retina in the left field where there is no blind spot.

Glossary**alkaloid**

substance, usually from a plant source, that is chemically basic with respect to pH and will stimulate bitter receptors

amacrine cell

type of cell in the retina that connects to the bipolar cells near the outer synaptic layer and provides the basis for early image processing within the retina

ampulla

in the ear, the structure at the base of a semicircular canal that contains the hair cells and cupula for transduction of rotational movement of the head

anosmia

loss of the sense of smell; usually the result of physical disruption of the first cranial nerve

aqueous humor

watery fluid that fills the anterior chamber containing the cornea, iris, ciliary body, and lens of the eye

audition

sense of hearing

auricle

fleshy external structure of the ear

basilar membrane

in the ear, the floor of the cochlear duct on which the organ of Corti sits

bipolar cell

cell type in the retina that connects the photoreceptors to the RGCs

capsaicin

molecule that activates nociceptors by interacting with a temperature-sensitive ion channel and is the basis for “hot” sensations in spicy food

chemoreceptor

sensory receptor cell that is sensitive to chemical stimuli, such as in taste, smell, or pain

choroid

highly vascular tissue in the wall of the eye that supplies the outer retina with blood

ciliary body

smooth muscle structure on the interior surface of the iris that controls the shape of the lens through the zonule fibers

cochlea

auditory portion of the inner ear containing structures to transduce sound stimuli

cochlear duct

space within the auditory portion of the inner ear that contains the organ of Corti and is adjacent to the scala tympani and scala vestibuli on either side

cone photoreceptor

one of the two types of retinal receptor cell that is specialized for color vision through the use of three photopigments distributed through three

separate populations of cells

contralateral

word meaning “on the opposite side,” as in axons that cross the midline in a fiber tract

cornea

fibrous covering of the anterior region of the eye that is transparent so that light can pass through it

cupula

specialized structure within the base of a semicircular canal that bends the stereocilia of hair cells when the head rotates by way of the relative movement of the enclosed fluid

encapsulated ending

configuration of a sensory receptor neuron with dendrites surrounded by specialized structures to aid in transduction of a particular type of sensation, such as the lamellated corpuscles in the deep dermis and subcutaneous tissue

equilibrium

sense of balance that includes sensations of position and movement of the head

external ear

structures on the lateral surface of the head, including the auricle and the ear canal back to the tympanic membrane

exteroceptor

sensory receptor that is positioned to interpret stimuli from the external environment, such as photoreceptors in the eye or somatosensory receptors in the skin

extraocular muscle

one of six muscles originating out of the bones of the orbit and inserting into the surface of the eye which are responsible for moving the eye

fibrous tunic

outer layer of the eye primarily composed of connective tissue known as the sclera and cornea

fovea

exact center of the retina at which visual stimuli are focused for maximal acuity, where the retina is thinnest, at which there is nothing but photoreceptors

free nerve ending

configuration of a sensory receptor neuron with dendrites in the connective tissue of the organ, such as in the dermis of the skin, that are most often sensitive to chemical, thermal, and mechanical stimuli

general sense

any sensory system that is distributed throughout the body and incorporated into organs of multiple other systems, such as the walls of the digestive organs or the skin

gustation

sense of taste

gustatory receptor cells

sensory cells in the taste bud that transduce the chemical stimuli of gustation

hair cells

mechanoreceptor cells found in the inner ear that transduce stimuli for the senses of hearing and balance

incus

(also, anvil) ossicle of the middle ear that connects the malleus to the stapes

inferior oblique

extraocular muscle responsible for lateral rotation of the eye

inferior rectus

extraocular muscle responsible for looking down

inner ear

structure within the temporal bone that contains the sensory apparatus of hearing and balance

inner segment

in the eye, the section of a photoreceptor that contains the nucleus and other major organelles for normal cellular functions

inner synaptic layer

layer in the retina where bipolar cells connect to RGCs

interoceptor

sensory receptor that is positioned to interpret stimuli from internal organs, such as stretch receptors in the wall of blood vessels

ipsilateral

word meaning on the same side, as in axons that do not cross the midline in a fiber tract

iris

colored portion of the anterior eye that surrounds the pupil

kinesthesia

sense of body movement based on sensations in skeletal muscles, tendons, joints, and the skin

lacrimal duct

duct in the medial corner of the orbit that drains tears into the nasal cavity

lacrimal gland

gland lateral to the orbit that produces tears to wash across the surface of the eye

lateral rectus

extraocular muscle responsible for abduction of the eye

lens

component of the eye that focuses light on the retina

levator palpebrae superioris

muscle that causes elevation of the upper eyelid, controlled by fibers in the oculomotor nerve

macula

enlargement at the base of a semicircular canal at which transduction of equilibrium stimuli takes place within the ampulla

malleus

(also, hammer) ossicle that is directly attached to the tympanic membrane

mechanoreceptor

receptor cell that transduces mechanical stimuli into an electrochemical signal

medial rectus

extraocular muscle responsible for adduction of the eye

middle ear

space within the temporal bone between the ear canal and bony labyrinth where the ossicles amplify sound waves from the tympanic membrane to the oval window

neural tunic

layer of the eye that contains nervous tissue, namely the retina

nociceptor

receptor cell that senses pain stimuli

odorant molecules

volatile chemicals that bind to receptor proteins in olfactory neurons to stimulate the sense of smell

olfaction

sense of smell

olfactory bulb

central target of the first cranial nerve; located on the ventral surface of the frontal lobe in the cerebrum

olfactory epithelium

region of the nasal epithelium where olfactory neurons are located

olfactory sensory neuron

receptor cell of the olfactory system, sensitive to the chemical stimuli of smell, the axons of which compose the first cranial nerve

opsin

protein that contains the photosensitive cofactor retinal for phototransduction

optic disc

spot on the retina at which RGC axons leave the eye and blood vessels of the inner retina pass

optic nerve

second cranial nerve, which is responsible visual sensation

organ of Corti

structure in the cochlea in which hair cells transduce movements from sound waves into electrochemical signals

osmoreceptor

receptor cell that senses differences in the concentrations of bodily fluids on the basis of osmotic pressure

ossicles

three small bones in the middle ear

otolith

layer of calcium carbonate crystals located on top of the otolithic membrane

otolithic membrane

gelatinous substance in the utricle and saccule of the inner ear that contains calcium carbonate crystals and into which the stereocilia of hair cells are embedded

outer segment

in the eye, the section of a photoreceptor that contains opsin molecules that transduce light stimuli

outer synaptic layer

layer in the retina at which photoreceptors connect to bipolar cells

oval window

membrane at the base of the cochlea where the stapes attaches, marking the beginning of the scala vestibuli

palpebral conjunctiva

membrane attached to the inner surface of the eyelids that covers the anterior surface of the cornea

papilla

for gustation, a bump-like projection on the surface of the tongue that contains taste buds

photoisomerization

chemical change in the retinal molecule that alters the bonding so that it switches from the 11-*cis*-retinal isomer to the all-*trans*-retinal isomer

photon

individual “packet” of light

photoreceptor

receptor cell specialized to respond to light stimuli

proprioception

sense of position and movement of the body

proprioceptor

receptor cell that senses changes in the position and kinesthetic aspects of the body

pupil

open hole at the center of the iris that light passes through into the eye

receptor cell

cell that transduces environmental stimuli into neural signals

retina

nervous tissue of the eye at which phototransduction takes place

retinal

cofactor in an opsin molecule that undergoes a biochemical change when struck by a photon (pronounced with a stress on the last syllable)

retinal ganglion cell (RGC)

neuron of the retina that projects along the second cranial nerve

rhodopsin

photopigment molecule found in the rod photoreceptors

rod photoreceptor

one of the two types of retinal receptor cell that is specialized for low-light vision

round window

membrane that marks the end of the scala tympani

sacculle

structure of the inner ear responsible for transducing linear acceleration in the vertical plane

scala tympani

portion of the cochlea that extends from the apex to the round window

scala vestibuli

portion of the cochlea that extends from the oval window to the apex

sclera

white of the eye

semicircular canals

structures within the inner ear responsible for transducing rotational movement information

sensory modality

a particular system for interpreting and perceiving environmental stimuli by the nervous system

somatosensation

general sense associated with modalities lumped together as touch

special sense

any sensory system associated with a specific organ structure, namely smell, taste, sight, hearing, and balance

spiral ganglion

location of neuronal cell bodies that transmit auditory information along the eighth cranial nerve

stapes

(also, stirrup) ossicle of the middle ear that is attached to the inner ear

stereocilia

array of apical membrane extensions in a hair cell that transduce movements when they are bent

submodality

specific sense within a broader major sense such as sweet as a part of the sense of taste, or color as a part of vision

superior oblique

extraocular muscle responsible for medial rotation of the eye

superior rectus

extraocular muscle responsible for looking up

taste buds

structures within a papilla on the tongue that contain gustatory receptor cells

tectorial membrane

component of the organ of Corti that lays over the hair cells, into which the stereocilia are embedded

thermoreceptor

sensory receptor specialized for temperature stimuli

topographical

relating to positional information

transduction

process of changing an environmental stimulus into the electrochemical signals of the nervous system

trochlea

cartilaginous structure that acts like a pulley for the superior oblique muscle

tympanic membrane

ear drum

umami

taste submodality for sensitivity to the concentration of amino acids; also called the savory sense

utricle

structure of the inner ear responsible for transducing linear acceleration in the horizontal plane

vascular tunic

middle layer of the eye primarily composed of connective tissue with a rich blood supply

vestibular ganglion

location of neuronal cell bodies that transmit equilibrium information along the eighth cranial nerve

vestibule

in the ear, the portion of the inner ear responsible for the sense of equilibrium

visceral sense

sense associated with the internal organs

vision

special sense of sight based on transduction of light stimuli

visual acuity

property of vision related to the sharpness of focus, which varies in relation to retinal position

vitreous humor

viscous fluid that fills the posterior chamber of the eye

zonule fibers

fibrous connections between the ciliary body and the lens

Central Processing

By the end of this section, you will be able to:

- Describe the pathways that sensory systems follow into the central nervous system
- Differentiate between the two major ascending pathways in the spinal cord
- Describe the pathway of somatosensory input from the face and compare it to the ascending pathways in the spinal cord
- Explain topographical representations of sensory information in at least two systems
- Describe two pathways of visual processing and the functions associated with each

Sensory Pathways

Specific regions of the CNS coordinate different somatic processes using sensory inputs and motor outputs of peripheral nerves. A simple case is a reflex caused by a synapse between a dorsal sensory neuron axon and a motor neuron in the ventral horn. More complex arrangements are possible to integrate peripheral sensory information with higher processes. The important regions of the CNS that play a role in somatic processes can be separated into the spinal cord brain stem, diencephalon, cerebral cortex, and subcortical structures.

Spinal Cord and Brain Stem

A sensory pathway that carries peripheral sensations to the brain is referred to as an **ascending pathway**, or ascending tract. The various sensory modalities each follow specific pathways through the CNS. Tactile and other somatosensory stimuli activate receptors in the skin, muscles, tendons, and joints throughout the entire body. However, the somatosensory pathways are divided into two separate systems on the basis of the location of the receptor neurons. Somatosensory stimuli from below the neck pass along the sensory pathways of the spinal cord, whereas somatosensory

stimuli from the head and neck travel through the cranial nerves—specifically, the trigeminal system.

The **dorsal column system** (sometimes referred to as the dorsal column–medial lemniscus) and the **spinothalamic tract** are two major pathways that bring sensory information to the brain ([\[link\]](#)). The sensory pathways in each of these systems are composed of three successive neurons.

The dorsal column system begins with the axon of a dorsal root ganglion neuron entering the dorsal root and joining the dorsal column white matter in the spinal cord. As axons of this pathway enter the dorsal column, they take on a positional arrangement so that axons from lower levels of the body position themselves medially, whereas axons from upper levels of the body position themselves laterally. The dorsal column is separated into two component tracts, the **fasciculus gracilis** that contains axons from the legs and lower body, and the **fasciculus cuneatus** that contains axons from the upper body and arms.

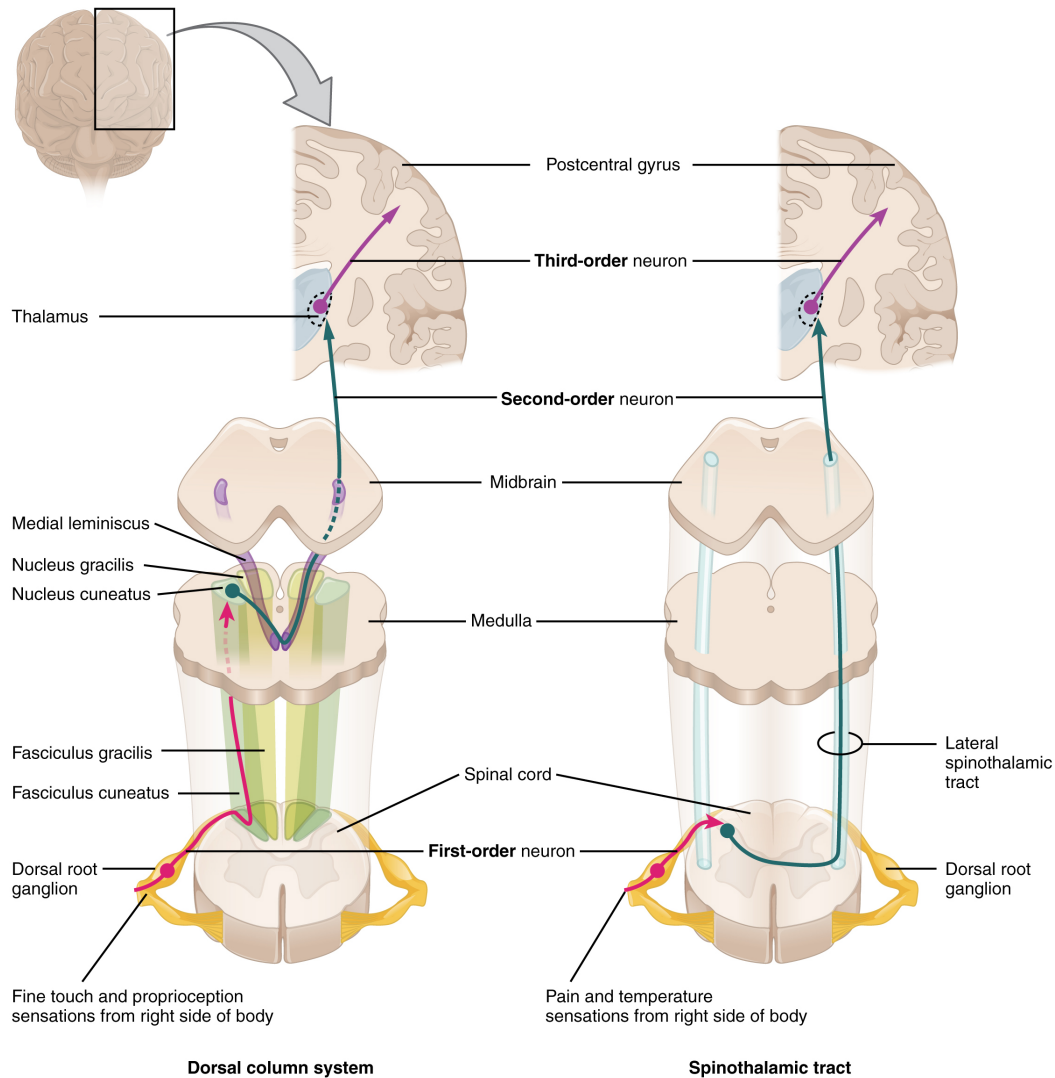
The axons in the dorsal column terminate in the nuclei of the medulla, where each synapses with the second neuron in their respective pathway. The **nucleus gracilis** is the target of fibers in the fasciculus gracilis, whereas the **nucleus cuneatus** is the target of fibers in the fasciculus cuneatus. The second neuron in the system projects from one of the two nuclei and then **decussates**, or crosses the midline of the medulla. These axons then continue to ascend the brain stem as a bundle called the **medial lemniscus**. These axons terminate in the thalamus, where each synapses with the third neuron in their respective pathway. The third neuron in the system projects its axons to the postcentral gyrus of the cerebral cortex, where somatosensory stimuli are initially processed and the conscious perception of the stimulus occurs.

The spinothalamic tract also begins with neurons in a dorsal root ganglion. These neurons extend their axons to the dorsal horn, where they synapse with the second neuron in their respective pathway. The name “spinothalamic” comes from this second neuron, which has its cell body in the spinal cord gray matter and connects to the thalamus. Axons from these second neurons then decussate within the spinal cord and ascend to the brain and enter the thalamus, where each synapses with the third neuron in

its respective pathway. The neurons in the thalamus then project their axons to the spinothalamic tract, which synapses in the postcentral gyrus of the cerebral cortex.

These two systems are similar in that they both begin with dorsal root ganglion cells, as with most general sensory information. The dorsal column system is primarily responsible for touch sensations and proprioception, whereas the spinothalamic tract pathway is primarily responsible for pain and temperature sensations. Another similarity is that the second neurons in both of these pathways are contralateral, because they project across the midline to the other side of the brain or spinal cord. In the dorsal column system, this decussation takes place in the brain stem; in the spinothalamic pathway, it takes place in the spinal cord at the same spinal cord level at which the information entered. The third neurons in the two pathways are essentially the same. In both, the second neuron synapses in the thalamus, and the thalamic neuron projects to the somatosensory cortex.

Ascending Sensory Pathways of the Spinal Cord



The dorsal column system and spinothalamic tract are the major ascending pathways that connect the periphery with the brain.

The trigeminal pathway carries somatosensory information from the face, head, mouth, and nasal cavity. As with the previously discussed nerve tracts, the sensory pathways of the trigeminal pathway each involve three successive neurons. First, axons from the trigeminal ganglion enter the brain stem at the level of the pons. These axons project to one of three locations. The **spinal trigeminal nucleus** of the medulla receives

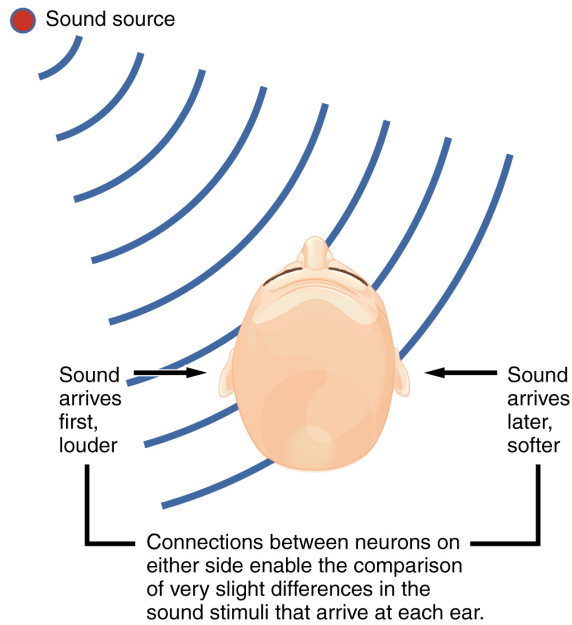
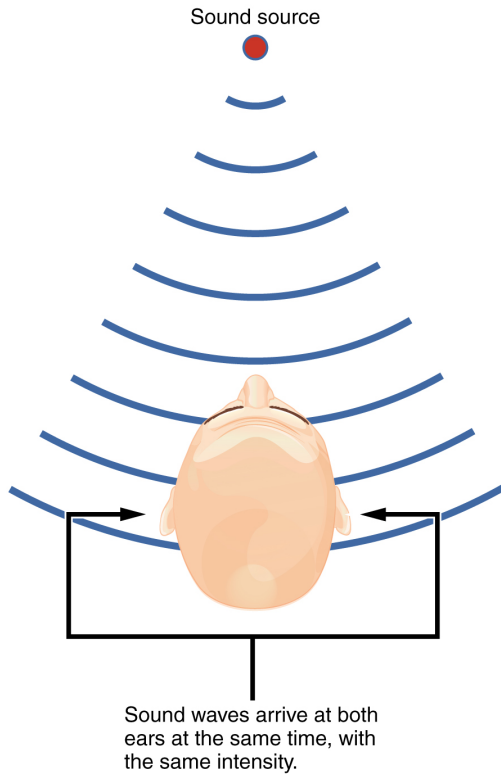
information similar to that carried by spinothalamic tract, such as pain and temperature sensations. Other axons go to either the **chief sensory nucleus** in the pons or the **mesencephalic nuclei** in the midbrain. These nuclei receive information like that carried by the dorsal column system, such as touch, pressure, vibration, and proprioception. Axons from the second neuron decussate and ascend to the thalamus along the trigeminothalamic tract. In the thalamus, each axon synapses with the third neuron in its respective pathway. Axons from the third neuron then project from the thalamus to the primary somatosensory cortex of the cerebrum.

The sensory pathway for gustation travels along the facial and glossopharyngeal cranial nerves, which synapse with neurons of the **solitary nucleus** in the brain stem. Axons from the solitary nucleus then project to the **ventral posterior nucleus** of the thalamus. Finally, axons from the ventral posterior nucleus project to the gustatory cortex of the cerebral cortex, where taste is processed and consciously perceived.

The sensory pathway for audition travels along the vestibulocochlear nerve, which synapses with neurons in the cochlear nuclei of the superior medulla. Within the brain stem, input from either ear is combined to extract location information from the auditory stimuli. Whereas the initial auditory stimuli received at the cochlea strictly represent the frequency—or pitch—of the stimuli, the locations of sounds can be determined by comparing information arriving at both ears.

Sound localization is a feature of central processing in the auditory nuclei of the brain stem. Sound localization is achieved by the brain calculating the **interaural time difference** and the **interaural intensity difference**. A sound originating from a specific location will arrive at each ear at different times, unless the sound is directly in front of the listener. If the sound source is slightly to the left of the listener, the sound will arrive at the left ear microseconds before it arrives at the right ear ([\[link\]](#)). This time difference is an example of an interaural time difference. Also, the sound will be slightly louder in the left ear than in the right ear because some of the sound waves reaching the opposite ear are blocked by the head. This is an example of an interaural intensity difference.

Auditory Brain Stem Mechanisms of Sound Localization



Localizing sound in the horizontal plane is achieved by processing in the medullary nuclei of the auditory system. Connections between neurons

on either side are able to
compare very slight
differences in sound stimuli
that arrive at either ear and
represent interaural time and
intensity differences.

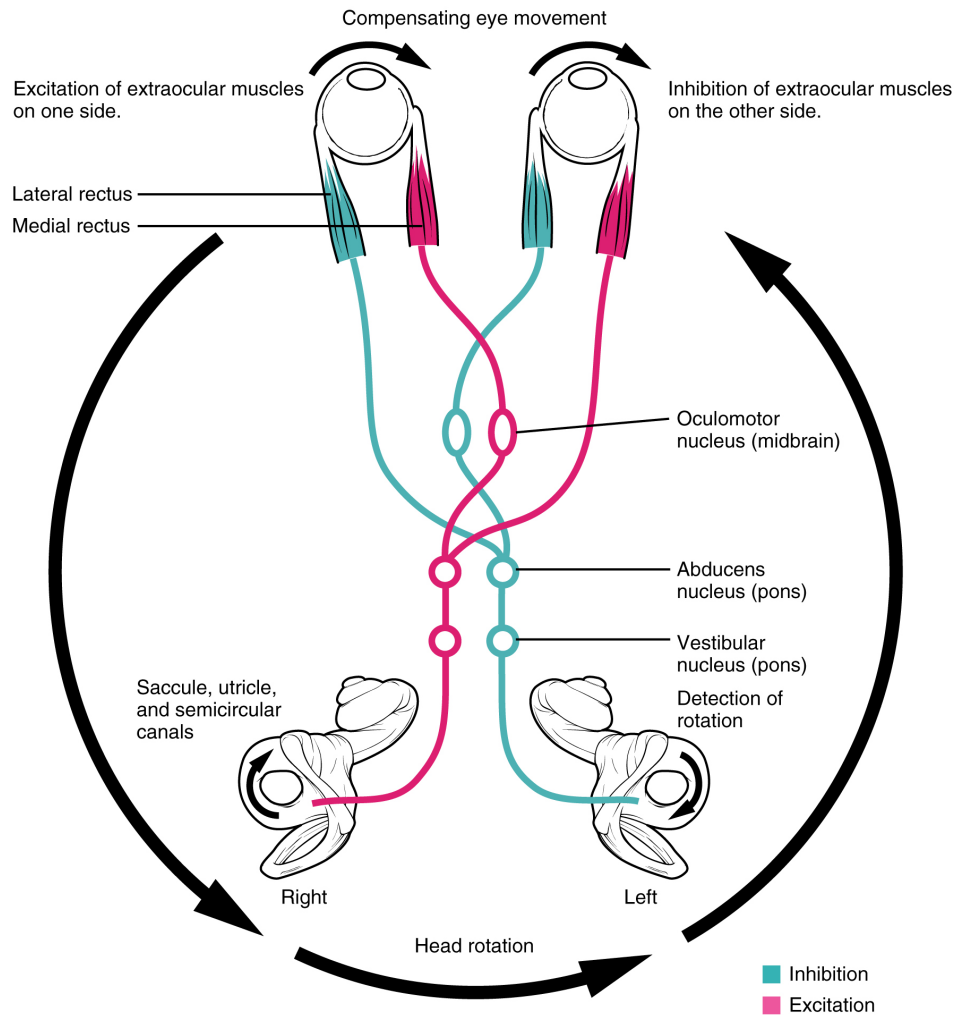
Auditory processing continues on to a nucleus in the midbrain called the **inferior colliculus**. Axons from the inferior colliculus project to two locations, the thalamus and the **superior colliculus**. The **medial geniculate nucleus** of the thalamus receives the auditory information and then projects that information to the auditory cortex in the temporal lobe of the cerebral cortex. The superior colliculus receives input from the visual and somatosensory systems, as well as the ears, to initiate stimulation of the muscles that turn the head and neck toward the auditory stimulus.

Balance is coordinated through the vestibular system, the nerves of which are composed of axons from the vestibular ganglion that carries information from the utricle, saccule, and semicircular canals. The system contributes to controlling head and neck movements in response to vestibular signals. An important function of the vestibular system is coordinating eye and head movements to maintain visual attention. Most of the axons terminate in the **vestibular nuclei** of the medulla. Some axons project from the vestibular ganglion directly to the cerebellum, with no intervening synapse in the vestibular nuclei. The cerebellum is primarily responsible for initiating movements on the basis of equilibrium information.

Neurons in the vestibular nuclei project their axons to targets in the brain stem. One target is the reticular formation, which influences respiratory and cardiovascular functions in relation to body movements. A second target of the axons of neurons in the vestibular nuclei is the spinal cord, which initiates the spinal reflexes involved with posture and balance. To assist the visual system, fibers of the vestibular nuclei project to the oculomotor, trochlear, and abducens nuclei to influence signals sent along the cranial nerves. These connections constitute the pathway of the **vestibulo-ocular**

reflex (VOR), which compensates for head and body movement by stabilizing images on the retina ([link](#)). Finally, the vestibular nuclei project to the thalamus to join the proprioceptive pathway of the dorsal column system, allowing conscious perception of equilibrium.

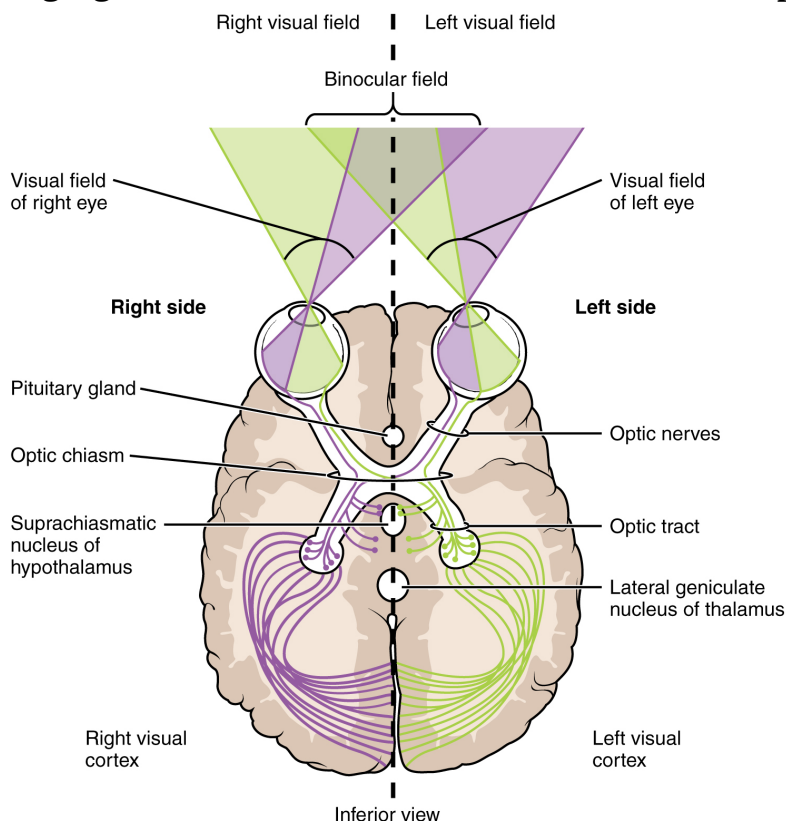
Vestibulo-ocular Reflex



Connections between the vestibular system and the cranial nerves controlling eye movement keep the eyes centered on a visual stimulus, even though the head is moving. During head movement, the eye muscles move the eyes in the opposite direction as the head movement, keeping the visual stimulus centered in the field of view.

The connections of the optic nerve are more complicated than those of other cranial nerves. Instead of the connections being between each eye and the brain, visual information is segregated between the left and right sides of the visual field. In addition, some of the information from one side of the visual field projects to the opposite side of the brain. Within each eye, the axons projecting from the medial side of the retina decussate at the **optic chiasm**. For example, the axons from the medial retina of the left eye cross over to the right side of the brain at the optic chiasm. However, within each eye, the axons projecting from the lateral side of the retina do not decussate. For example, the axons from the lateral retina of the right eye project back to the right side of the brain. Therefore the left field of view of each eye is processed on the right side of the brain, whereas the right field of view of each eye is processed on the left side of the brain ([\[link\]](#)).

Segregation of Visual Field Information at the Optic Chiasm



Contralateral visual field information from the lateral retina projects to the ipsilateral brain, whereas ipsilateral visual field

information has to decussate at the optic chiasm to reach the opposite side of the brain. (Note that this is an inferior view.)

A unique clinical presentation that relates to this anatomic arrangement is the loss of lateral peripheral vision, known as bilateral hemianopia. This is different from “tunnel vision” because the superior and inferior peripheral fields are not lost. Visual field deficits can be disturbing for a patient, but in this case, the cause is not within the visual system itself. A growth of the pituitary gland presses against the optic chiasm and interferes with signal transmission. However, the axons projecting to the same side of the brain are unaffected. Therefore, the patient loses the outermost areas of their field of vision and cannot see objects to their right and left.

Extending from the optic chiasm, the axons of the visual system are referred to as the **optic tract** instead of the optic nerve. The optic tract has three major targets, two in the diencephalon and one in the midbrain. The connection between the eyes and diencephalon is demonstrated during development, in which the neural tissue of the retina differentiates from that of the diencephalon by the growth of the secondary vesicles. The connections of the retina into the CNS are a holdover from this developmental association. The majority of the connections of the optic tract are to the thalamus—specifically, the **lateral geniculate nucleus**. Axons from this nucleus then project to the visual cortex of the cerebrum, located in the occipital lobe. Another target of the optic tract is the superior colliculus.

In addition, a very small number of RGC axons project from the optic chiasm to the **suprachiasmatic nucleus** of the hypothalamus. These RGCs are photosensitive, in that they respond to the presence or absence of light. Unlike the photoreceptors, however, these photosensitive RGCs cannot be used to perceive images. By simply responding to the absence or presence of light, these RGCs can send information about day length. The perceived proportion of sunlight to darkness establishes the **circadian rhythm** of our

bodies, allowing certain physiological events to occur at approximately the same time every day.

Diencephalon

The diencephalon is beneath the cerebrum and includes the thalamus and hypothalamus. In the somatic nervous system, the thalamus is an important relay for communication between the cerebrum and the rest of the nervous system. The hypothalamus has both somatic and autonomic functions. In addition, the hypothalamus communicates with the limbic system, which controls emotions and memory functions.

Sensory input to the thalamus comes from most of the special senses and ascending somatosensory tracts. Each sensory system is relayed through a particular nucleus in the thalamus. The thalamus is a required transfer point for most sensory tracts that reach the cerebral cortex, where conscious sensory perception begins. The one exception to this rule is the olfactory system. The olfactory tract axons from the olfactory bulb project directly to the cerebral cortex, along with the limbic system and hypothalamus.

The thalamus is a collection of several nuclei that can be categorized into three anatomical groups. White matter running through the thalamus defines the three major regions of the thalamus, which are an anterior nucleus, a medial nucleus, and a lateral group of nuclei. The anterior nucleus serves as a relay between the hypothalamus and the emotion and memory-producing limbic system. The medial nuclei serve as a relay for information from the limbic system and basal ganglia to the cerebral cortex. This allows memory creation during learning, but also determines alertness. The special and somatic senses connect to the lateral nuclei, where their information is relayed to the appropriate sensory cortex of the cerebrum.

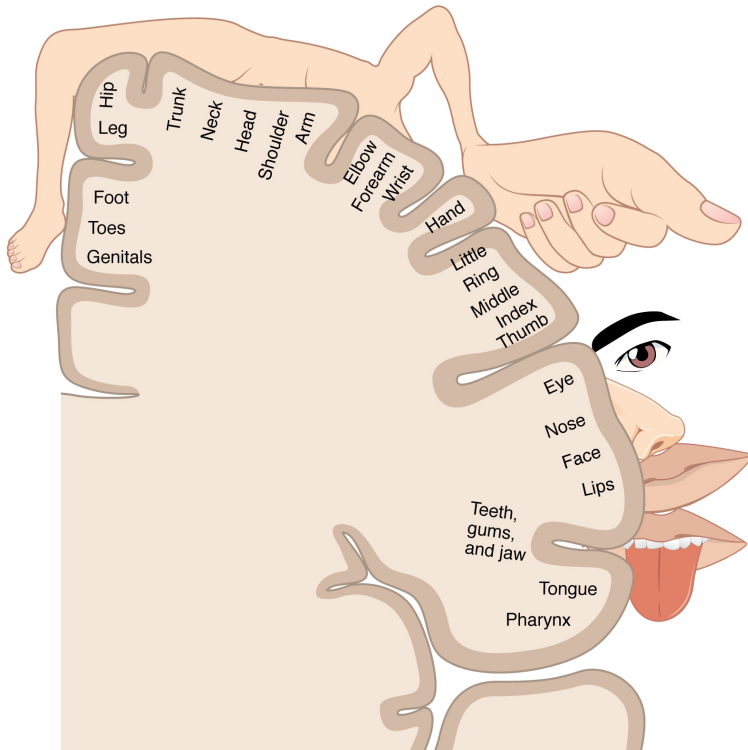
Cortical Processing

As described earlier, many of the sensory axons are positioned in the same way as their corresponding receptor cells in the body. This allows identification of the position of a stimulus on the basis of which receptor

cells are sending information. The cerebral cortex also maintains this sensory topography in the particular areas of the cortex that correspond to the position of the receptor cells. The somatosensory cortex provides an example in which, in essence, the locations of the somatosensory receptors in the body are mapped onto the somatosensory cortex. This mapping is often depicted using a **sensory homunculus** ([link](#)).

The term homunculus comes from the Latin word for “little man” and refers to a map of the human body that is laid across a portion of the cerebral cortex. In the somatosensory cortex, the external genitals, feet, and lower legs are represented on the medial face of the gyrus within the longitudinal fissure. As the gyrus curves out of the fissure and along the surface of the parietal lobe, the body map continues through the thighs, hips, trunk, shoulders, arms, and hands. The head and face are just lateral to the fingers as the gyrus approaches the lateral sulcus. The representation of the body in this topographical map is medial to lateral from the lower to upper body. It is a continuation of the topographical arrangement seen in the dorsal column system, where axons from the lower body are carried in the fasciculus gracilis, whereas axons from the upper body are carried in the fasciculus cuneatus. As the dorsal column system continues into the medial lemniscus, these relationships are maintained. Also, the head and neck axons running from the trigeminal nuclei to the thalamus run adjacent to the upper body fibers. The connections through the thalamus maintain topography such that the anatomic information is preserved. Note that this correspondence does not result in a perfectly miniature scale version of the body, but rather exaggerates the more sensitive areas of the body, such as the fingers and lower face. Less sensitive areas of the body, such as the shoulders and back, are mapped to smaller areas on the cortex.

The Sensory Homunculus



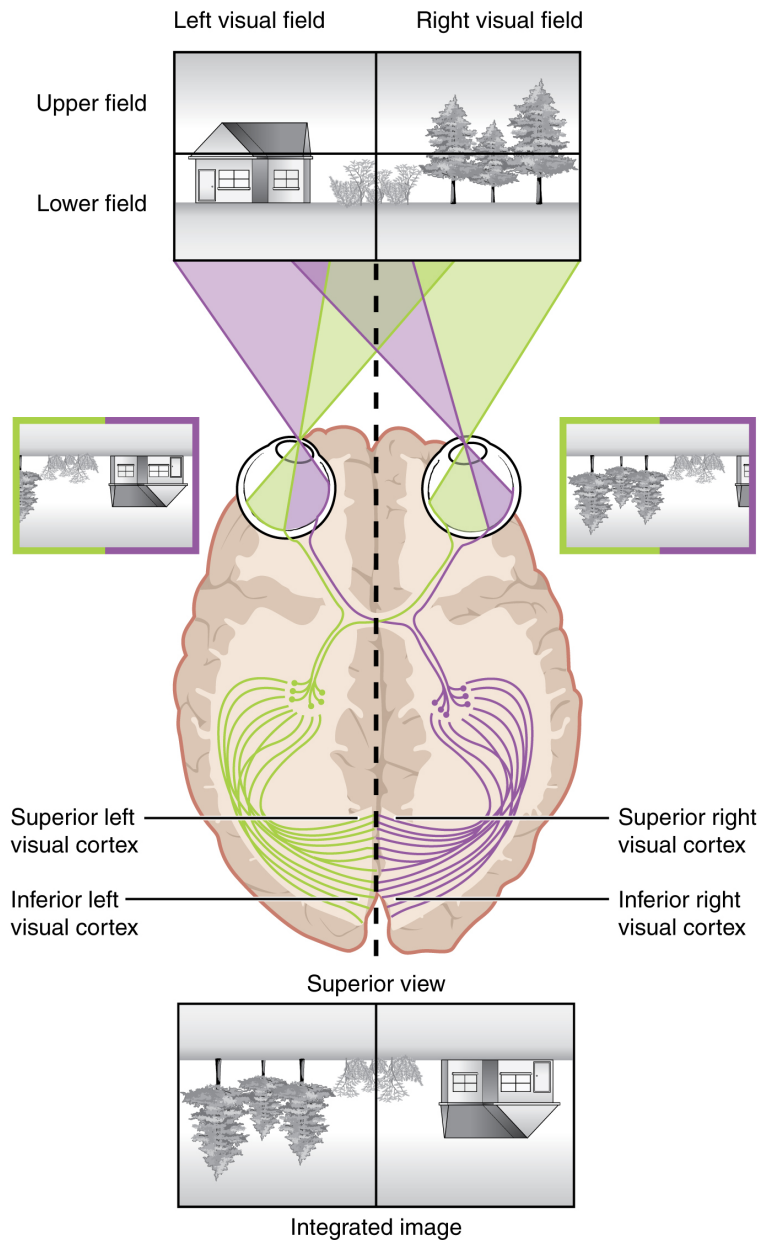
A cartoon representation of the sensory homunculus arranged adjacent to the cortical region in which the processing takes place.

Likewise, the topographic relationship between the retina and the visual cortex is maintained throughout the visual pathway. The visual field is projected onto the two retinae, as described above, with sorting at the optic chiasm. The right peripheral visual field falls on the medial portion of the right retina and the lateral portion of the left retina. The right medial retina then projects across the midline through the optic chiasm. This results in the right visual field being processed in the left visual cortex. Likewise, the left visual field is processed in the right visual cortex (see [\[link\]](#)). Though the chiasm is helping to sort right and left visual information, superior and inferior visual information is maintained topographically in the visual pathway. Light from the superior visual field falls on the inferior retina, and light from the inferior visual field falls on the superior retina. This

topography is maintained such that the superior region of the visual cortex processes the inferior visual field and vice versa. Therefore, the visual field information is inverted and reversed as it enters the visual cortex—up is down, and left is right. However, the cortex processes the visual information such that the final conscious perception of the visual field is correct. The topographic relationship is evident in that information from the foveal region of the retina is processed in the center of the primary visual cortex. Information from the peripheral regions of the retina are correspondingly processed toward the edges of the visual cortex. Similar to the exaggerations in the sensory homunculus of the somatosensory cortex, the foveal-processing area of the visual cortex is disproportionately larger than the areas processing peripheral vision.

In an experiment performed in the 1960s, subjects wore prism glasses so that the visual field was inverted before reaching the eye. On the first day of the experiment, subjects would duck when walking up to a table, thinking it was suspended from the ceiling. However, after a few days of acclimation, the subjects behaved as if everything were represented correctly. Therefore, the visual cortex is somewhat flexible in adapting to the information it receives from our eyes ([\[link\]](#)).

Topographic Mapping of the Retina onto the Visual Cortex



The visual field projects onto the retina through the lenses and falls on the retinae as an inverted, reversed image. The topography of this image is maintained as the visual information travels through the visual pathway to the cortex.

The cortex has been described as having specific regions that are responsible for processing specific information; there is the visual cortex, somatosensory cortex, gustatory cortex, etc. However, our experience of these senses is not divided. Instead, we experience what can be referred to as a seamless percept. Our perceptions of the various sensory modalities—though distinct in their content—are integrated by the brain so that we experience the world as a continuous whole.

In the cerebral cortex, sensory processing begins at the **primary sensory cortex**, then proceeds to an **association area**, and finally, into a **multimodal integration area**. For example, the visual pathway projects from the retinae through the thalamus to the primary visual cortex in the occipital lobe. This area is primarily in the medial wall within the longitudinal fissure. Here, visual stimuli begin to be recognized as basic shapes. Edges of objects are recognized and built into more complex shapes. Also, inputs from both eyes are compared to extract depth information. Because of the overlapping field of view between the two eyes, the brain can begin to estimate the distance of stimuli based on **binocular depth cues**.

Note:



Watch this [video](#) to learn more about how the brain perceives 3-D motion. Similar to how retinal disparity offers 3-D moviegoers a way to extract 3-D information from the two-dimensional visual field projected onto the retina, the brain can extract information about movement in space by comparing what the two eyes see. If movement of a visual stimulus is leftward in one eye and rightward in the opposite eye, the brain interprets this as movement toward (or away) from the face along the midline. If both

eyes see an object moving in the same direction, but at different rates, what would that mean for spatial movement?

Note:

Everyday Connections

Depth Perception, 3-D Movies, and Optical Illusions

The visual field is projected onto the retinal surface, where photoreceptors transduce light energy into neural signals for the brain to interpret. The retina is a two-dimensional surface, so it does not encode three-dimensional information. However, we can perceive depth. How is that accomplished?

Two ways in which we can extract depth information from the two-dimensional retinal signal are based on monocular cues and binocular cues, respectively. Monocular depth cues are those that are the result of information within the two-dimensional visual field. One object that overlaps another object has to be in front. Relative size differences are also a cue. For example, if a basketball appears larger than the basket, then the basket must be further away. On the basis of experience, we can estimate how far away the basket is. Binocular depth cues compare information represented in the two retinae because they do not see the visual field exactly the same.

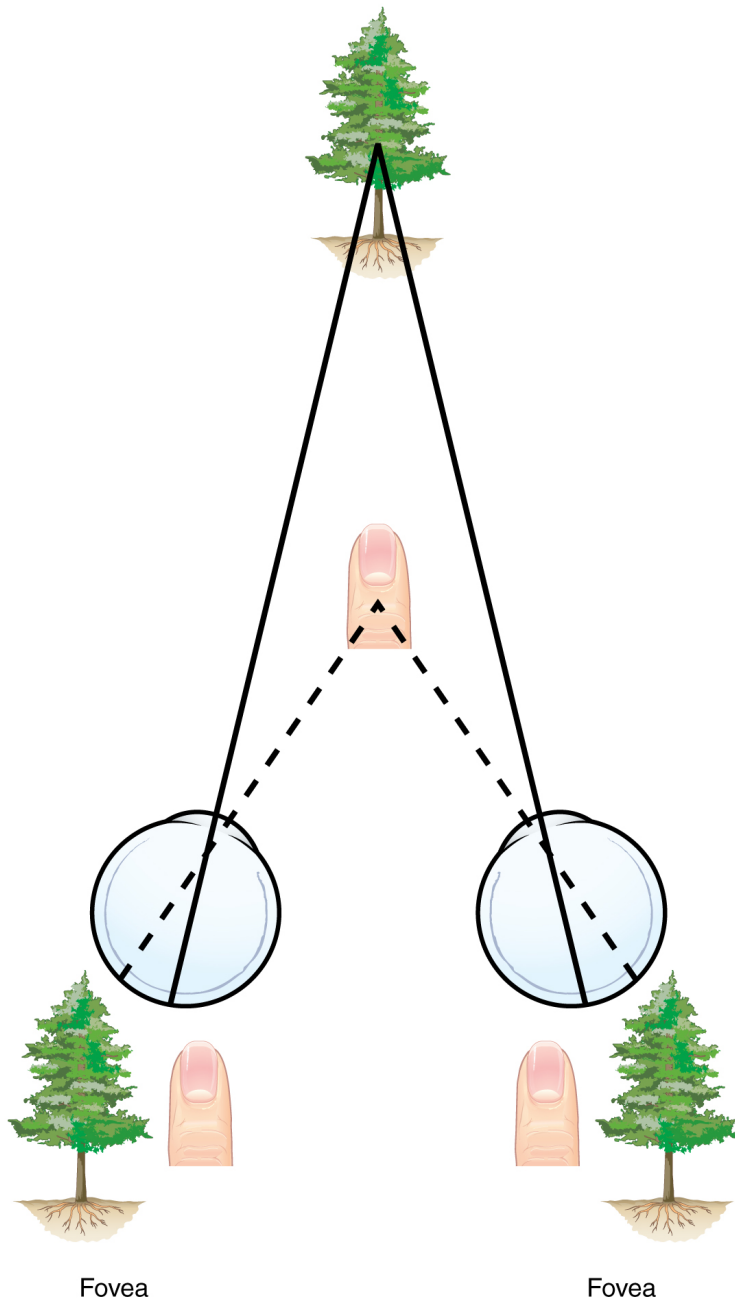
The centers of the two eyes are separated by a small distance, which is approximately 6 to 6.5 cm in most people. Because of this offset, visual stimuli do not fall on exactly the same spot on both retinae unless we are fixated directly on them and they fall on the fovea of each retina. All other objects in the visual field, either closer or farther away than the fixated object, will fall on different spots on the retina. When vision is fixed on an object in space, closer objects will fall on the lateral retina of each eye, and more distant objects will fall on the medial retina of either eye ([\[link\]](#)).

This is easily observed by holding a finger up in front of your face as you look at a more distant object. You will see two images of your finger that represent the two disparate images that are falling on either retina.

These depth cues, both monocular and binocular, can be exploited to make the brain think there are three dimensions in two-dimensional information. This is the basis of 3-D movies. The projected image on the screen is two

dimensional, but it has disparate information embedded in it. The 3-D glasses that are available at the theater filter the information so that only one eye sees one version of what is on the screen, and the other eye sees the other version. If you take the glasses off, the image on the screen will have varying amounts of blur because both eyes are seeing both layers of information, and the third dimension will not be evident. Some optical illusions can take advantage of depth cues as well, though those are more often using monocular cues to fool the brain into seeing different parts of the scene as being at different depths.

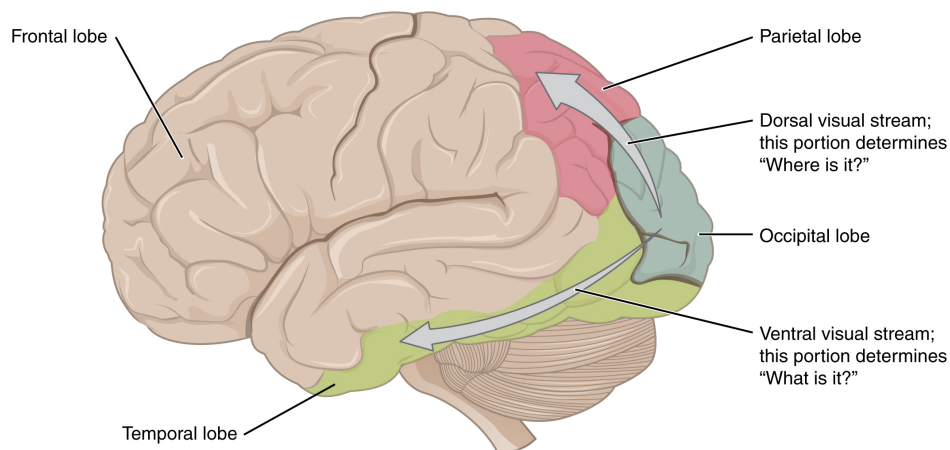
Retinal Disparity



Because of the interocular distance, which results in objects of different distances falling on different spots of the two retinae, the brain can extract depth perception from the two-dimensional information of the visual field.

There are two main regions that surround the primary cortex that are usually referred to as areas V2 and V3 (the primary visual cortex is area V1). These surrounding areas are the visual association cortex. The visual association regions develop more complex visual perceptions by adding color and motion information. The information processed in these areas is then sent to regions of the temporal and parietal lobes. Visual processing has two separate streams of processing: one into the temporal lobe and one into the parietal lobe. These are the ventral and dorsal streams, respectively ([link](#)). The **ventral stream** identifies visual stimuli and their significance. Because the ventral stream uses temporal lobe structures, it begins to interact with the non-visual cortex and may be important in visual stimuli becoming part of memories. The **dorsal stream** locates objects in space and helps in guiding movements of the body in response to visual inputs. The dorsal stream enters the parietal lobe, where it interacts with somatosensory cortical areas that are important for our perception of the body and its movements. The dorsal stream can then influence frontal lobe activity where motor functions originate.

Ventral and Dorsal Visual Streams



From the primary visual cortex in the occipital lobe, visual processing continues in two streams—one into the temporal lobe and one into the parietal lobe.

Note:

Disorders of the...

Brain: Prosopagnosia

The failures of sensory perception can be unusual and debilitating. A particular sensory deficit that inhibits an important social function of humans is prosopagnosia, or face blindness. The word comes from the Greek words *prosopa*, that means “faces,” and *agnosia*, that means “not knowing.” Some people may feel that they cannot recognize people easily by their faces. However, a person with prosopagnosia cannot recognize the most recognizable people in their respective cultures. They would not recognize the face of a celebrity, an important historical figure, or even a family member like their mother. They may not even recognize their own face.

Prosopagnosia can be caused by trauma to the brain, or it can be present from birth. The exact cause of prosopagnosia and the reason that it happens to some people is unclear. A study of the brains of people born with the deficit found that a specific region of the brain, the anterior fusiform gyrus of the temporal lobe, is often underdeveloped. This region of the brain is concerned with the recognition of visual stimuli and its possible association with memories. Though the evidence is not yet definitive, this region is likely to be where facial recognition occurs.

Though this can be a devastating condition, people who suffer from it can get by—often by using other cues to recognize the people they see. Often, the sound of a person’s voice, or the presence of unique cues such as distinct facial features (a mole, for example) or hair color can help the sufferer recognize a familiar person. In the video on prosopagnosia provided in this section, a woman is shown having trouble recognizing celebrities, family members, and herself. In some situations, she can use other cues to help her recognize faces.

Note:



The inability to recognize people by their faces is a troublesome problem. It can be caused by trauma, or it may be inborn. Watch this [video](#) to learn more about a person who lost the ability to recognize faces as the result of an injury. She cannot recognize the faces of close family members or herself. What other information can a person suffering from prosopagnosia use to figure out whom they are seeing?

Chapter Review

Sensory input to the brain enters through pathways that travel through either the spinal cord (for somatosensory input from the body) or the brain stem (for everything else, except the visual and olfactory systems) to reach the diencephalon. In the diencephalon, sensory pathways reach the thalamus. This is necessary for all sensory systems to reach the cerebral cortex, except for the olfactory system that is directly connected to the frontal and temporal lobes.

The two major tracts in the spinal cord, originating from sensory neurons in the dorsal root ganglia, are the dorsal column system and the spinothalamic tract. The major differences between the two are in the type of information that is relayed to the brain and where the tracts decussate. The dorsal column system primarily carries information about touch and proprioception and crosses the midline in the medulla. The spinothalamic tract is primarily responsible for pain and temperature sensation and crosses the midline in the spinal cord at the level at which it enters. The trigeminal nerve adds similar sensation information from the head to these pathways.

The auditory pathway passes through multiple nuclei in the brain stem in which additional information is extracted from the basic frequency stimuli

processed by the cochlea. Sound localization is made possible through the activity of these brain stem structures. The vestibular system enters the brain stem and influences activity in the cerebellum, spinal cord, and cerebral cortex.

The visual pathway segregates information from the two eyes so that one half of the visual field projects to the other side of the brain. Within visual cortical areas, the perception of the stimuli and their location is passed along two streams, one ventral and one dorsal. The ventral visual stream connects to structures in the temporal lobe that are important for long-term memory formation. The dorsal visual stream interacts with the somatosensory cortex in the parietal lobe, and together they can influence the activity in the frontal lobe to generate movements of the body in relation to visual information.

Interactive Link Questions

Exercise:

Problem:

Watch this [video](#) to learn more about how the brain perceives 3-D motion. Similar to how retinal disparity offers 3-D moviegoers a way to extract 3-D information from the two-dimensional visual field projected onto the retina, the brain can extract information about movement in space by comparing what the two eyes see. If movement of a visual stimulus is leftward in one eye and rightward in the opposite eye, the brain interprets this as movement toward (or away) from the face along the midline. If both eyes see an object moving in the same direction, but at different rates, what would that mean for spatial movement?

Solution:

Whereas the video shows opposite movement information in each eye for an object moving toward the face on the midline, movement past one side of the head will result in movement in the same direction on

both retinae, but it will be slower in the eye on the side nearer to the object.

Exercise:

Problem:

The inability to recognize people by their faces is a troublesome problem. It can be caused by trauma, or it may be inborn. Watch this [video](#) to learn more about a person who lost the ability to recognize faces as the result of an injury. She cannot recognize the faces of close family members or herself. What other information can a person suffering from prosopagnosia use to figure out whom they are seeing?

Solution:

Even if a person cannot recognize a person's face, other cues such as clothing, hairstyle, or a particular feature such as a prominent nose or facial hair, can help make an identification.

Review Questions

Exercise:

Problem:

Which of these sensory modalities does *not* pass through the ventral posterior thalamus?

- a. gustatory
- b. proprioception
- c. audition
- d. nociception

Solution:

C

Exercise:

Problem:

Which nucleus in the medulla is connected to the inferior colliculus?

- a. solitary nucleus
- b. vestibular nucleus
- c. chief sensory nucleus
- d. cochlear nucleus

Solution:

D

Exercise:

Problem:

Visual stimuli in the upper-left visual field will be processed in what region of the primary visual cortex?

- a. inferior right
- b. inferior left
- c. superior right
- d. superior left

Solution:

A

Exercise:

Problem:

Which location on the body has the largest region of somatosensory cortex representing it, according to the sensory homunculus?

- a. lips

- b. thigh
- c. elbow
- d. neck

Solution:

A

Exercise:

Problem:

Which of the following is a direct target of the vestibular ganglion?

- a. superior colliculus
- b. cerebellum
- c. thalamus
- d. optic chiasm

Solution:

B

Critical Thinking Questions

Exercise:

Problem:

Following a motorcycle accident, the victim loses the ability to move the right leg but has normal control over the left one, suggesting a hemisection somewhere in the thoracic region of the spinal cord. What sensory deficits would be expected in terms of touch versus pain? Explain your answer.

Solution:

The right leg would feel painful stimuli, but not touch, because the spinothalamic tract decussates at the level of entry, which would be below the injury, whereas the dorsal column system does not decussate until reaching the brain stem, which would be above the injury and thus those fibers would be damaged.

Exercise:**Problem:**

A pituitary tumor can cause perceptual losses in the lateral visual field. The pituitary gland is located directly inferior to the hypothalamus. Why would this happen?

Solution:

As the tumor enlarges, it would press against the optic chiasm, and fibers from the medial retina would be disrupted. These fibers carry information about the lateral visual field because the visual scene is reversed as the light passes through the pupil and lens.

Glossary

ascending pathway

fiber structure that relays sensory information from the periphery through the spinal cord and brain stem to other structures of the brain

association area

region of cortex connected to a primary sensory cortical area that further processes the information to generate more complex sensory perceptions

binocular depth cues

indications of the distance of visual stimuli on the basis of slight differences in the images projected onto either retina

chief sensory nucleus

component of the trigeminal nuclei that is found in the pons

circadian rhythm

internal perception of the daily cycle of light and dark based on retinal activity related to sunlight

decussate

to cross the midline, as in fibers that project from one side of the body to the other

dorsal column system

ascending tract of the spinal cord associated with fine touch and proprioceptive sensations

dorsal stream

connections between cortical areas from the occipital to parietal lobes that are responsible for the perception of visual motion and guiding movement of the body in relation to that motion

fasciculus cuneatus

lateral division of the dorsal column system composed of fibers from sensory neurons in the upper body

fasciculus gracilis

medial division of the dorsal column system composed of fibers from sensory neurons in the lower body

inferior colliculus

last structure in the auditory brainstem pathway that projects to the thalamus and superior colliculus

interaural intensity difference

cue used to aid sound localization in the horizontal plane that compares the relative loudness of sounds at the two ears, because the ear closer to the sound source will hear a slightly more intense sound

interaural time difference

cue used to help with sound localization in the horizontal plane that compares the relative time of arrival of sounds at the two ears, because

the ear closer to the sound source will receive the stimulus
microseconds before the other ear

lateral geniculate nucleus

thalamic target of the RGCs that projects to the visual cortex

medial geniculate nucleus

thalamic target of the auditory brain stem that projects to the auditory
cortex

medial lemniscus

fiber tract of the dorsal column system that extends from the nuclei
gracilis and cuneatus to the thalamus, and decussates

mesencephalic nucleus

component of the trigeminal nuclei that is found in the midbrain

multimodal integration area

region of the cerebral cortex in which information from more than one
sensory modality is processed to arrive at higher level cortical
functions such as memory, learning, or cognition

nucleus cuneatus

medullary nucleus at which first-order neurons of the dorsal column
system synapse specifically from the upper body and arms

nucleus gracilis

medullary nucleus at which first-order neurons of the dorsal column
system synapse specifically from the lower body and legs

optic chiasm

decussation point in the visual system at which medial retina fibers
cross to the other side of the brain

optic tract

name for the fiber structure containing axons from the retina posterior
to the optic chiasm representing their CNS location

primary sensory cortex

region of the cerebral cortex that initially receives sensory input from an ascending pathway from the thalamus and begins the processing that will result in conscious perception of that modality

sensory homunculus

topographic representation of the body within the somatosensory cortex demonstrating the correspondence between neurons processing stimuli and sensitivity

solitary nucleus

medullar nucleus that receives taste information from the facial and glossopharyngeal nerves

spinal trigeminal nucleus

component of the trigeminal nuclei that is found in the medulla

spinothalamic tract

ascending tract of the spinal cord associated with pain and temperature sensations

superior colliculus

structure in the midbrain that combines visual, auditory, and somatosensory input to coordinate spatial and topographic representations of the three sensory systems

suprachiasmatic nucleus

hypothalamic target of the retina that helps to establish the circadian rhythm of the body on the basis of the presence or absence of daylight

ventral posterior nucleus

nucleus in the thalamus that is the target of gustatory sensations and projects to the cerebral cortex

ventral stream

connections between cortical areas from the occipital lobe to the temporal lobe that are responsible for identification of visual stimuli

vestibular nuclei

targets of the vestibular component of the eighth cranial nerve

vestibulo-ocular reflex (VOR)

reflex based on connections between the vestibular system and the cranial nerves of eye movements that ensures images are stabilized on the retina as the head and body move

Motor Responses

By the end of this section, you will be able to:

- List the components of the basic processing stream for the motor system
- Describe the pathway of descending motor commands from the cortex to the skeletal muscles
- Compare different descending pathways, both by structure and function
- Explain the initiation of movement from the neurological connections
- Describe several reflex arcs and their functional roles

The defining characteristic of the somatic nervous system is that it controls skeletal muscles. Somatic senses inform the nervous system about the external environment, but the response to that is through voluntary muscle movement. The term “voluntary” suggests that there is a conscious decision to make a movement. However, some aspects of the somatic system use voluntary muscles without conscious control. One example is the ability of our breathing to switch to unconscious control while we are focused on another task. However, the muscles that are responsible for the basic process of breathing are also utilized for speech, which is entirely voluntary.

Cortical Responses

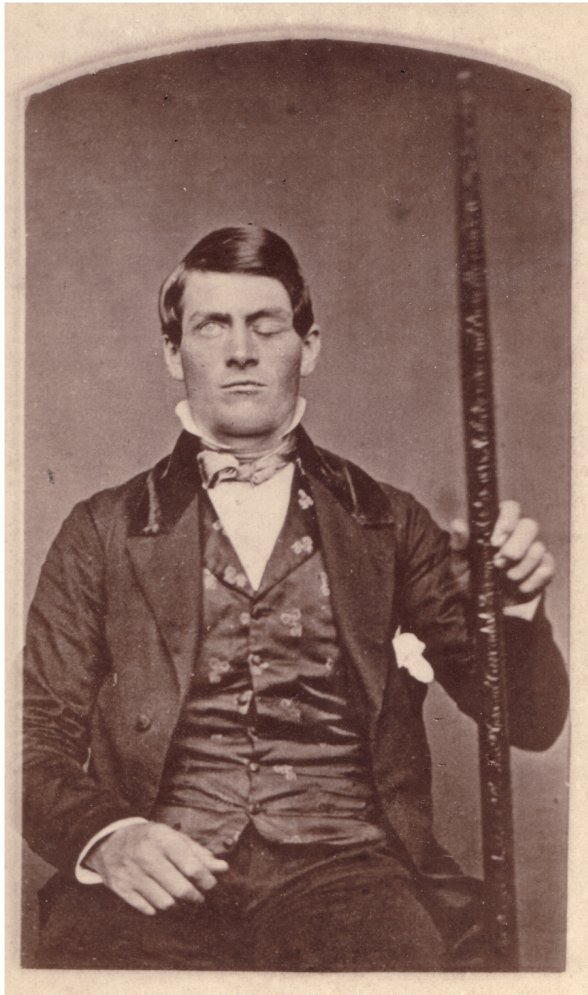
Let’s start with sensory stimuli that have been registered through receptor cells and the information relayed to the CNS along ascending pathways. In the cerebral cortex, the initial processing of sensory perception progresses to associative processing and then integration in multimodal areas of cortex. These levels of processing can lead to the incorporation of sensory perceptions into memory, but more importantly, they lead to a response. The completion of cortical processing through the primary, associative, and integrative sensory areas initiates a similar progression of motor processing, usually in different cortical areas.

Whereas the sensory cortical areas are located in the occipital, temporal, and parietal lobes, motor functions are largely controlled by the frontal lobe. The most anterior regions of the frontal lobe—the prefrontal areas—

are important for **executive functions**, which are those cognitive functions that lead to goal-directed behaviors. These higher cognitive processes include **working memory**, which has been called a “mental scratch pad,” that can help organize and represent information that is not in the immediate environment. The prefrontal lobe is responsible for aspects of attention, such as inhibiting distracting thoughts and actions so that a person can focus on a goal and direct behavior toward achieving that goal.

The functions of the prefrontal cortex are integral to the personality of an individual, because it is largely responsible for what a person intends to do and how they accomplish those plans. A famous case of damage to the prefrontal cortex is that of Phineas Gage, dating back to 1848. He was a railroad worker who had a metal spike impale his prefrontal cortex ([\[link\]](#)). He survived the accident, but according to second-hand accounts, his personality changed drastically. Friends described him as no longer acting like himself. Whereas he was a hardworking, amiable man before the accident, he turned into an irritable, temperamental, and lazy man after the accident. Many of the accounts of his change may have been inflated in the retelling, and some behavior was likely attributable to alcohol used as a pain medication. However, the accounts suggest that some aspects of his personality did change. Also, there is new evidence that though his life changed dramatically, he was able to become a functioning stagecoach driver, suggesting that the brain has the ability to recover even from major trauma such as this.

Phineas Gage



The victim of an accident while working on a railroad in 1848, Phineas Gage had a large iron rod impaled through the prefrontal cortex of his frontal lobe. After the accident, his personality appeared to change, but he eventually learned to cope with the trauma and lived as a coach driver even after such a traumatic event. (credit b: John M. Harlow, MD)

Secondary Motor Cortices

In generating motor responses, the executive functions of the prefrontal cortex will need to initiate actual movements. One way to define the prefrontal area is any region of the frontal lobe that does not elicit movement when electrically stimulated. These are primarily in the anterior part of the frontal lobe. The regions of the frontal lobe that remain are the regions of the cortex that produce movement. The prefrontal areas project into the secondary motor cortices, which include the **premotor cortex** and the **supplemental motor area**.

Two important regions that assist in planning and coordinating movements are located adjacent to the primary motor cortex. The premotor cortex is more lateral, whereas the supplemental motor area is more medial and superior. The premotor area aids in controlling movements of the core muscles to maintain posture during movement, whereas the supplemental motor area is hypothesized to be responsible for planning and coordinating movement. The supplemental motor area also manages sequential movements that are based on prior experience (that is, learned movements). Neurons in these areas are most active leading up to the initiation of movement. For example, these areas might prepare the body for the movements necessary to drive a car in anticipation of a traffic light changing.

Adjacent to these two regions are two specialized motor planning centers. The **frontal eye fields** are responsible for moving the eyes in response to visual stimuli. There are direct connections between the frontal eye fields and the superior colliculus. Also, anterior to the premotor cortex and primary motor cortex is **Broca's area**. This area is responsible for controlling movements of the structures of speech production. The area is named after a French surgeon and anatomist who studied patients who could not produce speech. They did not have impairments to understanding speech, only to producing speech sounds, suggesting a damaged or underdeveloped Broca's area.

Primary Motor Cortex

The primary motor cortex is located in the precentral gyrus of the frontal lobe. A neurosurgeon, Walter Penfield, described much of the basic understanding of the primary motor cortex by electrically stimulating the surface of the cerebrum. Penfield would probe the surface of the cortex while the patient was only under local anesthesia so that he could observe responses to the stimulation. This led to the belief that the precentral gyrus directly stimulated muscle movement. We now know that the primary motor cortex receives input from several areas that aid in planning movement, and its principle output stimulates spinal cord neurons to stimulate skeletal muscle contraction.

The primary motor cortex is arranged in a similar fashion to the primary somatosensory cortex, in that it has a topographical map of the body, creating a motor homunculus (see [\[link\]](#)). The neurons responsible for musculature in the feet and lower legs are in the medial wall of the precentral gyrus, with the thighs, trunk, and shoulder at the crest of the longitudinal fissure. The hand and face are in the lateral face of the gyrus. Also, the relative space allotted for the different regions is exaggerated in muscles that have greater enervation. The greatest amount of cortical space is given to muscles that perform fine, agile movements, such as the muscles of the fingers and the lower face. The “power muscles” that perform coarser movements, such as the buttock and back muscles, occupy much less space on the motor cortex.

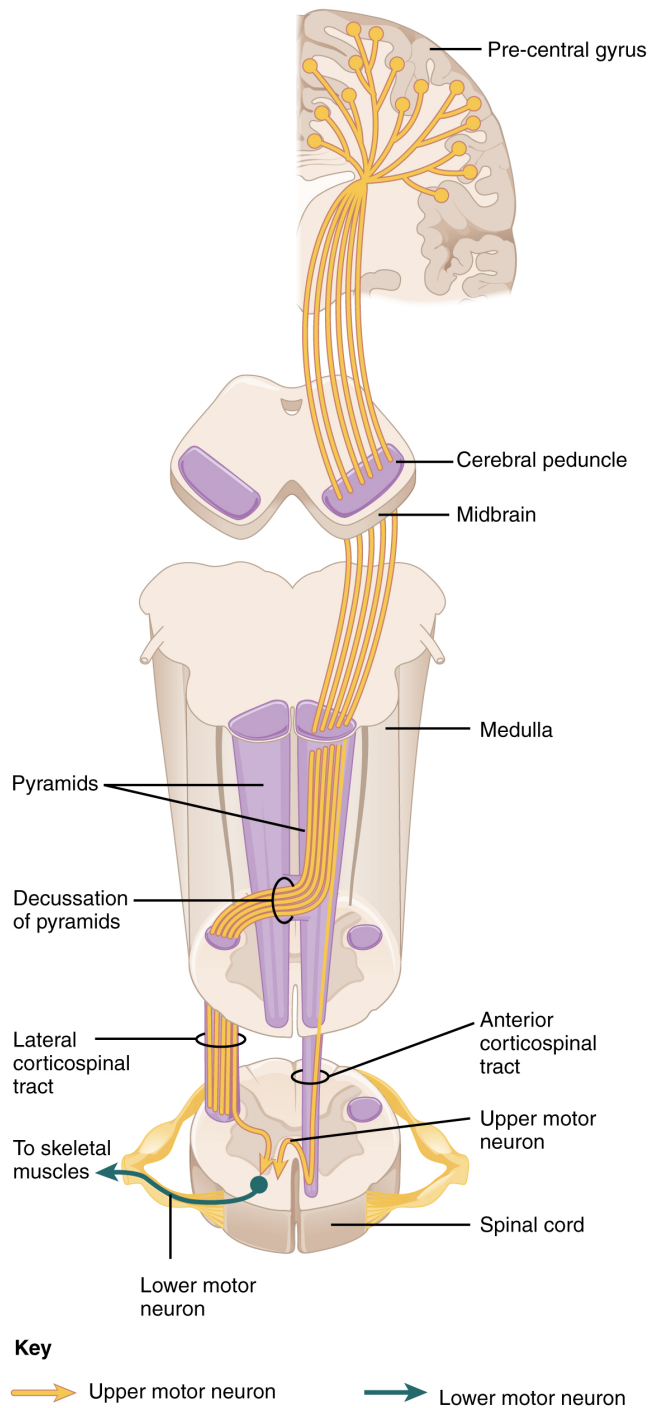
Descending Pathways

The motor output from the cortex descends into the brain stem and to the spinal cord to control the musculature through motor neurons. Neurons located in the primary motor cortex, named **Betz cells**, are large cortical neurons that synapse with lower motor neurons in the brain stem or in the spinal cord. The two descending pathways travelled by the axons of Betz cells are the **corticobulbar tract** and the **corticospinal tract**, respectively. Both tracts are named for their origin in the cortex and their targets—either the brain stem (the term “bulbar” refers to the brain stem as the bulb, or enlargement, at the top of the spinal cord) or the spinal cord.

These two descending pathways are responsible for the conscious or voluntary movements of skeletal muscles. Any motor command from the primary motor cortex is sent down the axons of the Betz cells to activate upper motor neurons in either the cranial motor nuclei or in the ventral horn of the spinal cord. The axons of the corticobulbar tract are ipsilateral, meaning they project from the cortex to the motor nucleus on the same side of the nervous system. Conversely, the axons of the corticospinal tract are largely contralateral, meaning that they cross the midline of the brain stem or spinal cord and synapse on the opposite side of the body. Therefore, the right motor cortex of the cerebrum controls muscles on the left side of the body, and vice versa.

The corticospinal tract descends from the cortex through the deep white matter of the cerebrum. It then passes between the caudate nucleus and putamen of the basal nuclei as a bundle called the **internal capsule**. The tract then passes through the midbrain as the **cerebral peduncles**, after which it burrows through the pons. Upon entering the medulla, the tracts make up the large white matter tract referred to as the **pyramids** ([\[link\]](#)). The defining landmark of the medullary-spinal border is the **pyramidal decussation**, which is where most of the fibers in the corticospinal tract cross over to the opposite side of the brain. At this point, the tract separates into two parts, which have control over different domains of the musculature.

Corticospinal Tract



The major descending tract that controls skeletal muscle movements is the corticospinal tract. It is composed of two neurons, the upper motor neuron

and the lower motor neuron. The upper motor neuron has its cell body in the primary motor cortex of the frontal lobe and synapses on the lower motor neuron, which is in the ventral horn of the spinal cord and projects to the skeletal muscle in the periphery.

Appendicular Control

The **lateral corticospinal tract** is composed of the fibers that cross the midline at the pyramidal decussation (see [\[link\]](#)). The axons cross over from the anterior position of the pyramids in the medulla to the lateral column of the spinal cord. These axons are responsible for controlling appendicular muscles.

This influence over the appendicular muscles means that the lateral corticospinal tract is responsible for moving the muscles of the arms and legs. The ventral horn in both the lower cervical spinal cord and the lumbar spinal cord both have wider ventral horns, representing the greater number of muscles controlled by these motor neurons. The **cervical enlargement** is particularly large because there is greater control over the fine musculature of the upper limbs, particularly of the fingers. The **lumbar enlargement** is not as significant in appearance because there is less fine motor control of the lower limbs.

Axial Control

The **anterior corticospinal tract** is responsible for controlling the muscles of the body trunk (see [\[link\]](#)). These axons do not decussate in the medulla. Instead, they remain in an anterior position as they descend the brain stem

and enter the spinal cord. These axons then travel to the spinal cord level at which they synapse with a lower motor neuron. Upon reaching the appropriate level, the axons decussate, entering the ventral horn on the opposite side of the spinal cord from which they entered. In the ventral horn, these axons synapse with their corresponding lower motor neurons. The lower motor neurons are located in the medial regions of the ventral horn, because they control the axial muscles of the trunk.

Because movements of the body trunk involve both sides of the body, the anterior corticospinal tract is not entirely contralateral. Some collateral branches of the tract will project into the ipsilateral ventral horn to control synergistic muscles on that side of the body, or to inhibit antagonistic muscles through interneurons within the ventral horn. Through the influence of both sides of the body, the anterior corticospinal tract can coordinate postural muscles in broad movements of the body. These coordinating axons in the anterior corticospinal tract are often considered bilateral, as they are both ipsilateral and contralateral.

Note:



Watch this [video](#) to learn more about the descending motor pathway for the somatic nervous system. The autonomic connections are mentioned, which are covered in another chapter. From this brief video, only some of the descending motor pathway of the somatic nervous system is described. Which division of the pathway is described and which division is left out?

Extrapyramidal Controls

Other descending connections between the brain and the spinal cord are called the **extrapyramidal system**. The name comes from the fact that this system is outside the corticospinal pathway, which includes the pyramids in the medulla. A few pathways originating from the brain stem contribute to this system.

The **tectospinal tract** projects from the midbrain to the spinal cord and is important for postural movements that are driven by the superior colliculus. The name of the tract comes from an alternate name for the superior colliculus, which is the tectum. The **reticulospinal tract** connects the reticular system, a diffuse region of gray matter in the brain stem, with the spinal cord. This tract influences trunk and proximal limb muscles related to posture and locomotion. The reticulospinal tract also contributes to muscle tone and influences autonomic functions. The **vestibulospinal tract** connects the brain stem nuclei of the vestibular system with the spinal cord. This allows posture, movement, and balance to be modulated on the basis of equilibrium information provided by the vestibular system.

The pathways of the extrapyramidal system are influenced by subcortical structures. For example, connections between the secondary motor cortices and the extrapyramidal system modulate spine and cranium movements. The basal nuclei, which are important for regulating movement initiated by the CNS, influence the extrapyramidal system as well as its thalamic feedback to the motor cortex.

The conscious movement of our muscles is more complicated than simply sending a single command from the precentral gyrus down to the proper motor neurons. During the movement of any body part, our muscles relay information back to the brain, and the brain is constantly sending “revised” instructions back to the muscles. The cerebellum is important in contributing to the motor system because it compares cerebral motor commands with proprioceptive feedback. The corticospinal fibers that project to the ventral horn of the spinal cord have branches that also synapse in the pons, which project to the cerebellum. Also, the proprioceptive sensations of the dorsal column system have a collateral projection to the medulla that projects to the cerebellum. These two streams of information are compared in the cerebellar cortex. Conflicts between the

motor commands sent by the cerebrum and body position information provided by the proprioceptors cause the cerebellum to stimulate the **red nucleus** of the midbrain. The red nucleus then sends corrective commands to the spinal cord along the **rubrospinal tract**. The name of this tract comes from the word for red that is seen in the English word “ruby.”

A good example of how the cerebellum corrects cerebral motor commands can be illustrated by walking in water. An original motor command from the cerebrum to walk will result in a highly coordinated set of learned movements. However, in water, the body cannot actually perform a typical walking movement as instructed. The cerebellum can alter the motor command, stimulating the leg muscles to take larger steps to overcome the water resistance. The cerebellum can make the necessary changes through the rubrospinal tract. Modulating the basic command to walk also relies on spinal reflexes, but the cerebellum is responsible for calculating the appropriate response. When the cerebellum does not work properly, coordination and balance are severely affected. The most dramatic example of this is during the overconsumption of alcohol. Alcohol inhibits the ability of the cerebellum to interpret proprioceptive feedback, making it more difficult to coordinate body movements, such as walking a straight line, or guide the movement of the hand to touch the tip of the nose.

Note:



Visit this [site](#) to read about an elderly woman who starts to lose the ability to control fine movements, such as speech and the movement of limbs. Many of the usual causes were ruled out. It was not a stroke, Parkinson’s disease, diabetes, or thyroid dysfunction. The next most obvious cause was medication, so her pharmacist had to be consulted. The side effect of a drug meant to help her sleep had resulted in changes in motor control.

What regions of the nervous system are likely to be the focus of haloperidol side effects?

Ventral Horn Output

The somatic nervous system provides output strictly to skeletal muscles. The lower motor neurons, which are responsible for the contraction of these muscles, are found in the ventral horn of the spinal cord. These large, multipolar neurons have a corona of dendrites surrounding the cell body and an axon that extends out of the ventral horn. This axon travels through the ventral nerve root to join the emerging spinal nerve. The axon is relatively long because it needs to reach muscles in the periphery of the body. The diameters of cell bodies may be on the order of hundreds of micrometers to support the long axon; some axons are a meter in length, such as the lumbar motor neurons that innervate muscles in the first digits of the feet.

The axons will also branch to innervate multiple muscle fibers. Together, the motor neuron and all the muscle fibers that it controls make up a motor unit. Motor units vary in size. Some may contain up to 1000 muscle fibers, such as in the quadriceps, or they may only have 10 fibers, such as in an extraocular muscle. The number of muscle fibers that are part of a motor unit corresponds to the precision of control of that muscle. Also, muscles that have finer motor control have more motor units connecting to them, and this requires a larger topographical field in the primary motor cortex.

Motor neuron axons connect to muscle fibers at a neuromuscular junction. This is a specialized synaptic structure at which multiple axon terminals synapse with the muscle fiber sarcolemma. The synaptic end bulbs of the motor neurons secrete acetylcholine, which binds to receptors on the sarcolemma. The binding of acetylcholine opens ligand-gated ion channels, increasing the movement of cations across the sarcolemma. This depolarizes the sarcolemma, initiating muscle contraction. Whereas other synapses result in graded potentials that must reach a threshold in the postsynaptic target, activity at the neuromuscular junction reliably leads to muscle fiber contraction with every nerve impulse received from a motor

neuron. However, the strength of contraction and the number of fibers that contract can be affected by the frequency of the motor neuron impulses.

Reflexes

This chapter began by introducing reflexes as an example of the basic elements of the somatic nervous system. Simple somatic reflexes do not include the higher centers discussed for conscious or voluntary aspects of movement. Reflexes can be spinal or cranial, depending on the nerves and central components that are involved. The example described at the beginning of the chapter involved heat and pain sensations from a hot stove causing withdrawal of the arm through a connection in the spinal cord that leads to contraction of the biceps brachii. The description of this withdrawal reflex was simplified, for the sake of the introduction, to emphasize the parts of the somatic nervous system. But to consider reflexes fully, more attention needs to be given to this example.

As you withdraw your hand from the stove, you do not want to slow that reflex down. As the biceps brachii contracts, the antagonistic triceps brachii needs to relax. Because the neuromuscular junction is strictly excitatory, the biceps will contract when the motor nerve is active. Skeletal muscles do not actively relax. Instead the motor neuron needs to “quiet down,” or be inhibited. In the hot-stove withdrawal reflex, this occurs through an interneuron in the spinal cord. The interneuron’s cell body is located in the dorsal horn of the spinal cord. The interneuron receives a synapse from the axon of the sensory neuron that detects that the hand is being burned. In response to this stimulation from the sensory neuron, the interneuron then inhibits the motor neuron that controls the triceps brachii. This is done by releasing a neurotransmitter or other signal that hyperpolarizes the motor neuron connected to the triceps brachii, making it less likely to initiate an action potential. With this motor neuron being inhibited, the triceps brachii relaxes. Without the antagonistic contraction, withdrawal from the hot stove is faster and keeps further tissue damage from occurring.

Another example of a withdrawal reflex occurs when you step on a painful stimulus, like a tack or a sharp rock. The nociceptors that are activated by the painful stimulus activate the motor neurons responsible for contraction

of the tibialis anterior muscle. This causes dorsiflexion of the foot. An inhibitory interneuron, activated by a collateral branch of the nociceptor fiber, will inhibit the motor neurons of the gastrocnemius and soleus muscles to cancel plantar flexion. An important difference in this reflex is that plantar flexion is most likely in progress as the foot is pressing down onto the tack. Contraction of the tibialis anterior is not the most important aspect of the reflex, as continuation of plantar flexion will result in further damage from stepping onto the tack.

Another type of reflex is a **stretch reflex**. In this reflex, when a skeletal muscle is stretched, a muscle spindle receptor is activated. The axon from this receptor structure will cause direct contraction of the muscle. A collateral of the muscle spindle fiber will also inhibit the motor neuron of the antagonist muscles. The reflex helps to maintain muscles at a constant length. A common example of this reflex is the knee jerk that is elicited by a rubber hammer struck against the patellar ligament in a physical exam.

A specialized reflex to protect the surface of the eye is the **corneal reflex**, or the eye blink reflex. When the cornea is stimulated by a tactile stimulus, or even by bright light in a related reflex, blinking is initiated. The sensory component travels through the trigeminal nerve, which carries somatosensory information from the face, or through the optic nerve, if the stimulus is bright light. The motor response travels through the facial nerve and innervates the orbicularis oculi on the same side. This reflex is commonly tested during a physical exam using an air puff or a gentle touch of a cotton-tipped applicator.

Note:



Watch this [video](#) to learn more about the reflex arc of the corneal reflex. When the right cornea senses a tactile stimulus, what happens to the left eye? Explain your answer.

Note:



Watch this [video](#) to learn more about newborn reflexes. Newborns have a set of reflexes that are expected to have been crucial to survival before the modern age. These reflexes disappear as the baby grows, as some of them may be unnecessary as they age. The video demonstrates a reflex called the Babinski reflex, in which the foot flexes dorsally and the toes splay out when the sole of the foot is lightly scratched. This is normal for newborns, but it is a sign of reduced myelination of the spinal tract in adults. Why would this reflex be a problem for an adult?

Chapter Review

The motor components of the somatic nervous system begin with the frontal lobe of the brain, where the prefrontal cortex is responsible for higher functions such as working memory. The integrative and associate functions of the prefrontal lobe feed into the secondary motor areas, which help plan movements. The premotor cortex and supplemental motor area then feed into the primary motor cortex that initiates movements. Large Betz cells project through the corticobulbar and corticospinal tracts to synapse on lower motor neurons in the brain stem and ventral horn of the spinal cord, respectively. These connections are responsible for generating movements of skeletal muscles.

The extrapyramidal system includes projections from the brain stem and higher centers that influence movement, mostly to maintain balance and posture, as well as to maintain muscle tone. The superior colliculus and red nucleus in the midbrain, the vestibular nuclei in the medulla, and the reticular formation throughout the brain stem each have tracts projecting to the spinal cord in this system. Descending input from the secondary motor cortices, basal nuclei, and cerebellum connect to the origins of these tracts in the brain stem.

All of these motor pathways project to the spinal cord to synapse with motor neurons in the ventral horn of the spinal cord. These lower motor neurons are the cells that connect to skeletal muscle and cause contractions. These neurons project through the spinal nerves to connect to the muscles at neuromuscular junctions. One motor neuron connects to multiple muscle fibers within a target muscle. The number of fibers that are innervated by a single motor neuron varies on the basis of the precision necessary for that muscle and the amount of force necessary for that motor unit. The quadriceps, for example, have many fibers controlled by single motor neurons for powerful contractions that do not need to be precise. The extraocular muscles have only a small number of fibers controlled by each motor neuron because moving the eyes does not require much force, but needs to be very precise.

Reflexes are the simplest circuits within the somatic nervous system. A withdrawal reflex from a painful stimulus only requires the sensory fiber that enters the spinal cord and the motor neuron that projects to a muscle. Antagonist and postural muscles can be coordinated with the withdrawal, making the connections more complex. The simple, single neuronal connection is the basis of somatic reflexes. The corneal reflex is contraction of the orbicularis oculi muscle to blink the eyelid when something touches the surface of the eye. Stretch reflexes maintain a constant length of muscles by causing a contraction of a muscle to compensate for a stretch that can be sensed by a specialized receptor called a muscle spindle.

Interactive Link Questions

Exercise:

Problem:

Watch this [video](#) to learn more about the descending motor pathway for the somatic nervous system. The autonomic connections are mentioned, which are covered in another chapter. From this brief video, only some of the descending motor pathway of the somatic nervous system is described. Which division of the pathway is described and which division is left out?

Solution:

The video only describes the lateral division of the corticospinal tract. The anterior division is omitted.

Exercise:**Problem:**

Visit this [site](#) to read about an elderly woman who starts to lose the ability to control fine movements, such as speech and the movement of limbs. Many of the usual causes were ruled out. It was not a stroke, Parkinson's disease, diabetes, or thyroid dysfunction. The next most obvious cause was medication, so her pharmacist had to be consulted. The side effect of a drug meant to help her sleep had resulted in changes in motor control. What regions of the nervous system are likely to be the focus of haloperidol side effects?

Solution:

The movement disorders were similar to those seen in movement disorders of the extrapyramidal system, which would mean the basal nuclei are the most likely source of haloperidol side effects. In fact, haloperidol affects dopamine activity, which is a prominent part of the chemistry of the basal nuclei.

Exercise:

Problem:

Watch this [video](#) to learn more about the reflex arc of the corneal reflex. When the right cornea senses a tactile stimulus, what happens to the left eye? Explain your answer.

Solution:

The left eye also blinks. The sensory input from one eye activates the motor response of both eyes so that they both blink.

Exercise:**Problem:**

Watch this [video](#) to learn more about newborn reflexes. Newborns have a set of reflexes that are expected to have been crucial to survival before the modern age. These reflexes disappear as the baby grows, as some of them may be unnecessary as they age. The video demonstrates a reflex called the Babinski reflex, in which the foot flexes dorsally and the toes splay out when the sole of the foot is lightly scratched. This is normal for newborns, but it is a sign of reduced myelination of the spinal tract in adults. Why would this reflex be a problem for an adult?

Solution:

While walking, the sole of the foot may be scraped or scratched by many things. If the foot still reacted as in the Babinski reflex, an adult might lose their balance while walking.

Chapter Review**Exercise:**

Problem:

Which region of the frontal lobe is responsible for initiating movement by directly connecting to cranial and spinal motor neurons?

- a. prefrontal cortex
- b. supplemental motor area
- c. premotor cortex
- d. primary motor cortex

Solution:

D

Exercise:**Problem:**

Which extrapyramidal tract incorporates equilibrium sensations with motor commands to aid in posture and movement?

- a. tectospinal tract
- b. vestibulospinal tract
- c. reticulospinal tract
- d. corticospinal tract

Solution:

B

Exercise:**Problem:**

Which region of gray matter in the spinal cord contains motor neurons that innervate skeletal muscles?

- a. ventral horn

- b. dorsal horn
- c. lateral horn
- d. lateral column

Solution:

A

Exercise:

Problem:

What type of reflex can protect the foot when a painful stimulus is sensed?

- a. stretch reflex
- b. gag reflex
- c. withdrawal reflex
- d. corneal reflex

Solution:

C

Exercise:

Problem:

What is the name for the topographical representation of the sensory input to the somatosensory cortex?

- a. homunculus
- b. homo sapiens
- c. postcentral gyrus
- d. primary cortex

Solution:

A

Critical Thinking Questions

Exercise:

Problem:

The prefrontal lobotomy is a drastic—and largely out-of-practice—procedure used to disconnect that portion of the cerebral cortex from the rest of the frontal lobe and the diencephalon as a psychiatric therapy. Why would this have been thought necessary for someone with a potentially uncontrollable behavior?

Solution:

The prefrontal cortex is involved in decision-making functions that lead to motor responses through connections to the more posterior motor regions. These early aspects of behavior are often associated with a person's personality, so disrupting those connections will lead to severe changes in behavior.

Exercise:

Problem:

If a reflex is a limited circuit within the somatic system, why do physical and neurological exams include them to test the health of an individual?

Solution:

Though reflexes are simple circuits within the nervous system, they are representative of the more involved circuits of the somatic nervous system and can be used to quickly assess the state of neurological function for a person.

Glossary

anterior corticospinal tract

division of the corticospinal pathway that travels through the ventral (anterior) column of the spinal cord and controls axial musculature through the medial motor neurons in the ventral (anterior) horn

Betz cells

output cells of the primary motor cortex that cause musculature to move through synapses on cranial and spinal motor neurons

Broca's area

region of the frontal lobe associated with the motor commands necessary for speech production

cerebral peduncles

segments of the descending motor pathway that make up the white matter of the ventral midbrain

cervical enlargement

region of the ventral (anterior) horn of the spinal cord that has a larger population of motor neurons for the greater number of and finer control of muscles of the upper limb

corneal reflex

protective response to stimulation of the cornea causing contraction of the orbicularis oculi muscle resulting in blinking of the eye

corticobulbar tract

connection between the cortex and the brain stem responsible for generating movement

corticospinal tract

connection between the cortex and the spinal cord responsible for generating movement

executive functions

cognitive processes of the prefrontal cortex that lead to directing goal-directed behavior, which is a precursor to executing motor commands

extrapyramidal system

pathways between the brain and spinal cord that are separate from the corticospinal tract and are responsible for modulating the movements generated through that primary pathway

frontal eye fields

area of the prefrontal cortex responsible for moving the eyes to attend to visual stimuli

internal capsule

segment of the descending motor pathway that passes between the caudate nucleus and the putamen

lateral corticospinal tract

division of the corticospinal pathway that travels through the lateral column of the spinal cord and controls appendicular musculature through the lateral motor neurons in the ventral (anterior) horn

lumbar enlargement

region of the ventral (anterior) horn of the spinal cord that has a larger population of motor neurons for the greater number of muscles of the lower limb

premotor cortex

cortical area anterior to the primary motor cortex that is responsible for planning movements

pyramidal decussation

location at which corticospinal tract fibers cross the midline and segregate into the anterior and lateral divisions of the pathway

pyramids

segment of the descending motor pathway that travels in the anterior position of the medulla

red nucleus

midbrain nucleus that sends corrective commands to the spinal cord along the rubrospinal tract, based on disparity between an original

command and the sensory feedback from movement

reticulospinal tract

extrapyramidal connections between the brain stem and spinal cord that modulate movement, contribute to posture, and regulate muscle tone

rubrospinal tract

descending motor control pathway, originating in the red nucleus, that mediates control of the limbs on the basis of cerebellar processing

stretch reflex

response to activation of the muscle spindle stretch receptor that causes contraction of the muscle to maintain a constant length

supplemental motor area

cortical area anterior to the primary motor cortex that is responsible for planning movements

tectospinal tract

extrapyramidal connections between the superior colliculus and spinal cord

vestibulospinal tract

extrapyramidal connections between the vestibular nuclei in the brain stem and spinal cord that modulate movement and contribute to balance on the basis of the sense of equilibrium

working memory

function of the prefrontal cortex to maintain a representation of information that is not in the immediate environment

Introduction

class="introduction"

Fight or Flight?

Though the threats that modern humans face are not large predators, the autonomic nervous system is adapted to this type of stimulus.

The modern world presents stimuli that trigger the same response.

(credit:
Vernon
Swanepoel
)



Note:

Chapter Objectives

After studying this chapter, you will be able to:

- Describe the components of the autonomic nervous system
- Differentiate between the structures of the sympathetic and parasympathetic divisions in the autonomic nervous system
- Name the components of a visceral reflex specific to the autonomic division to which it belongs
- Predict the response of a target effector to autonomic input on the basis of the released signaling molecule
- Describe how the central nervous system coordinates and contributes to autonomic functions

The autonomic nervous system is often associated with the “fight-or-flight response,” which refers to the preparation of the body to either run away

from a threat or to stand and fight in the face of that threat. To suggest what this means, consider the (very unlikely) situation of seeing a lioness hunting out on the savannah. Though this is not a common threat that humans deal with in the modern world, it represents the type of environment in which the human species thrived and adapted. The spread of humans around the world to the present state of the modern age occurred much more quickly than any species would adapt to environmental pressures such as predators. However, the reactions modern humans have in the modern world are based on these prehistoric situations. If your boss is walking down the hallway on Friday afternoon looking for “volunteers” to come in on the weekend, your response is the same as the prehistoric human seeing the lioness running across the savannah: fight or flight.

Most likely, your response to your boss—not to mention the lioness—would be flight. Run away! The autonomic system is responsible for the physiological response to make that possible, and hopefully successful. Adrenaline starts to flood your circulatory system. Your heart rate increases. Sweat glands become active. The bronchi of the lungs dilate to allow more air exchange. Pupils dilate to increase visual information. Blood pressure increases in general, and blood vessels dilate in skeletal muscles. Time to run. Similar physiological responses would occur in preparation for fighting off the threat.

This response should sound a bit familiar. The autonomic nervous system is tied into emotional responses as well, and the fight-or-flight response probably sounds like a panic attack. In the modern world, these sorts of reactions are associated with anxiety as much as with response to a threat. It is engrained in the nervous system to respond like this. In fact, the adaptations of the autonomic nervous system probably predate the human species and are likely to be common to all mammals, and perhaps shared by many animals. That lioness might herself be threatened in some other situation.

However, the autonomic nervous system is not just about responding to threats. Besides the fight-or-flight response, there are the responses referred to as “rest and digest.” If that lioness is successful in her hunting, then she is going to rest from the exertion. Her heart rate will slow. Breathing will

return to normal. The digestive system has a big job to do. Much of the function of the autonomic system is based on the connections within an autonomic, or visceral, reflex.

Divisions of the Autonomic Nervous System

By the end of this section, you will be able to:

- Name the components that generate the sympathetic and parasympathetic responses of the autonomic nervous system
- Explain the differences in output connections within the two divisions of the autonomic nervous system
- Describe the signaling molecules and receptor proteins involved in communication within the two divisions of the autonomic nervous system

The nervous system can be divided into two functional parts: the somatic nervous system and the autonomic nervous system. The major differences between the two systems are evident in the responses that each produces. The somatic nervous system causes contraction of skeletal muscles. The autonomic nervous system controls cardiac and smooth muscle, as well as glandular tissue. The somatic nervous system is associated with voluntary responses (though many can happen without conscious awareness, like breathing), and the autonomic nervous system is associated with involuntary responses, such as those related to homeostasis.

The autonomic nervous system regulates many of the internal organs through a balance of two aspects, or divisions. In addition to the endocrine system, the autonomic nervous system is instrumental in homeostatic mechanisms in the body. The two divisions of the autonomic nervous system are the **sympathetic division** and the **parasympathetic division**. The sympathetic system is associated with the **fight-or-flight response**, and parasympathetic activity is referred to by the epithet of **rest and digest**. Homeostasis is the balance between the two systems. At each target effector, dual innervation determines activity. For example, the heart receives connections from both the sympathetic and parasympathetic divisions. One causes heart rate to increase, whereas the other causes heart rate to decrease.

Note:



Watch this [video](#) to learn more about adrenaline and the fight-or-flight response. When someone is said to have a rush of adrenaline, the image of bungee jumpers or skydivers usually comes to mind. But adrenaline, also known as epinephrine, is an important chemical in coordinating the body's fight-or-flight response. In this video, you look inside the physiology of the fight-or-flight response, as envisioned for a firefighter. His body's reaction is the result of the sympathetic division of the autonomic nervous system causing system-wide changes as it prepares for extreme responses. What two changes does adrenaline bring about to help the skeletal muscle response?

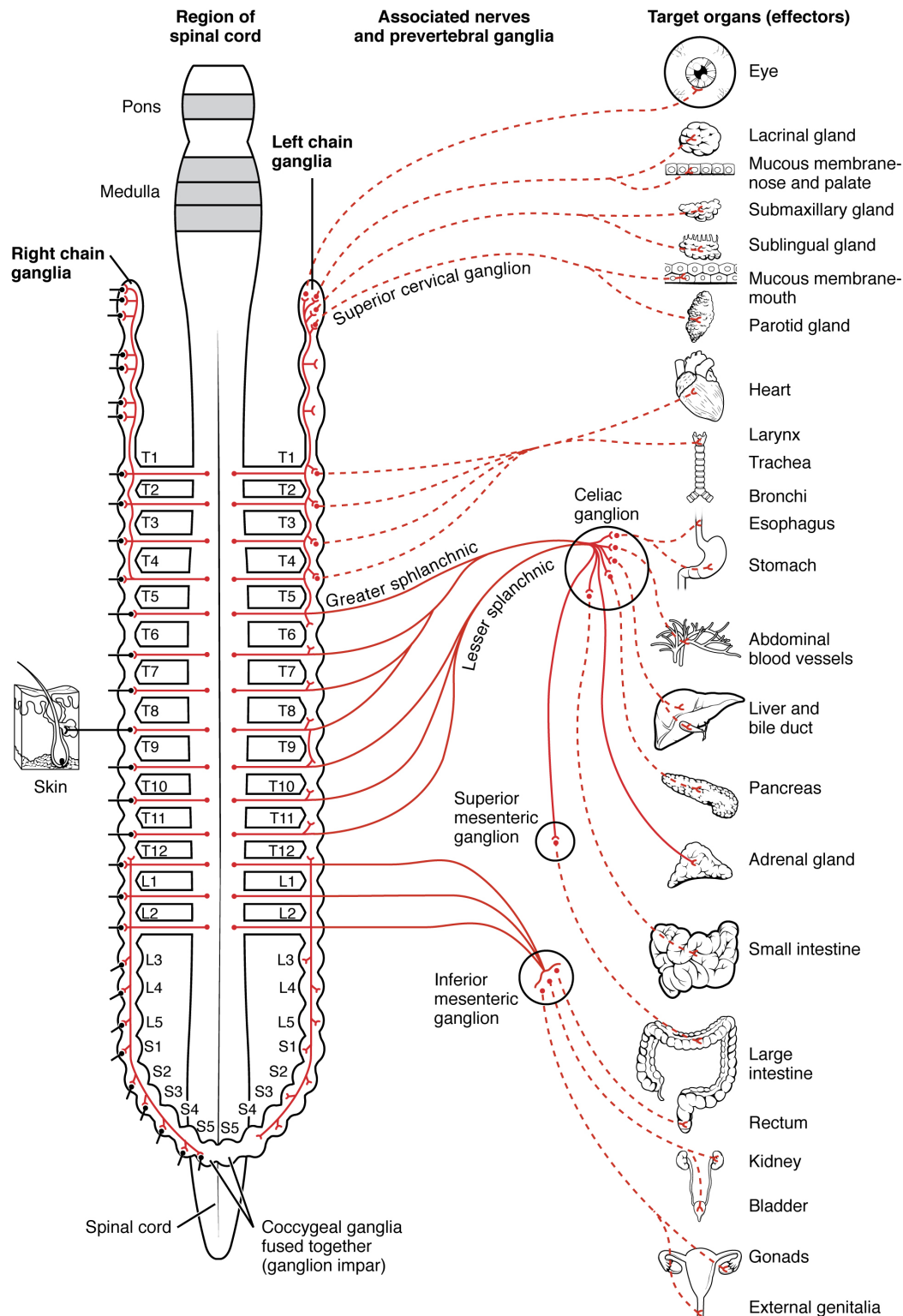
Sympathetic Division of the Autonomic Nervous System

To respond to a threat—to fight or to run away—the sympathetic system causes divergent effects as many different effector organs are activated together for a common purpose. More oxygen needs to be inhaled and delivered to skeletal muscle. The respiratory, cardiovascular, and musculoskeletal systems are all activated together. Additionally, sweating keeps the excess heat that comes from muscle contraction from causing the body to overheat. The digestive system shuts down so that blood is not absorbing nutrients when it should be delivering oxygen to skeletal muscles. To coordinate all these responses, the connections in the sympathetic system diverge from a limited region of the central nervous system (CNS) to a wide array of ganglia that project to the many effector organs simultaneously. The complex set of structures that compose the output of the sympathetic system make it possible for these disparate effectors to come together in a coordinated, systemic change.

The sympathetic division of the autonomic nervous system influences the various organ systems of the body through connections emerging from the thoracic and upper lumbar spinal cord. It is referred to as the **thoracolumbar system** to reflect this anatomical basis. A **central neuron** in the lateral horn of any of these spinal regions projects to ganglia adjacent to the vertebral column through the ventral spinal roots. The majority of ganglia of the sympathetic system belong to a network of **sympathetic chain ganglia** that runs alongside the vertebral column. The ganglia appear as a series of clusters of neurons linked by axonal bridges. There are typically 23 ganglia in the chain on either side of the spinal column. Three correspond to the cervical region, 12 are in the thoracic region, four are in the lumbar region, and four correspond to the sacral region. The cervical and sacral levels are not connected to the spinal cord directly through the spinal roots, but through ascending or descending connections through the bridges within the chain.

A diagram that shows the connections of the sympathetic system is somewhat like a circuit diagram that shows the electrical connections between different receptacles and devices. In [\[link\]](#), the “circuits” of the sympathetic system are intentionally simplified.

Connections of Sympathetic Division of the Autonomic Nervous System



Neurons from the lateral horn of the spinal cord (preganglionic nerve fibers - solid lines) project to the chain ganglia on either side of the vertebral column or to

collateral (prevertebral) ganglia that are anterior to the vertebral column in the abdominal cavity. Axons from these ganglionic neurons (postganglionic nerve fibers - dotted lines) then project to target effectors throughout the body.

To continue with the analogy of the circuit diagram, there are three different types of “junctions” that operate within the sympathetic system ([\[link\]](#)). The first type is most direct: the sympathetic nerve projects to the chain ganglion at the same level as the **target effector** (the organ, tissue, or gland to be innervated). An example of this type is spinal nerve T1 that synapses with the T1 chain ganglion to innervate the trachea. The fibers of this branch are called **white rami communicantes** (singular = ramus communicans); they are myelinated and therefore referred to as white (see [\[link\]a](#)). The axon from the central neuron (the preganglionic fiber shown as a solid line) synapses with the **ganglionic neuron** (with the postganglionic fiber shown as a dashed line). This neuron then projects to a target effector—in this case, the trachea—via **gray rami communicantes**, which are unmyelinated axons.

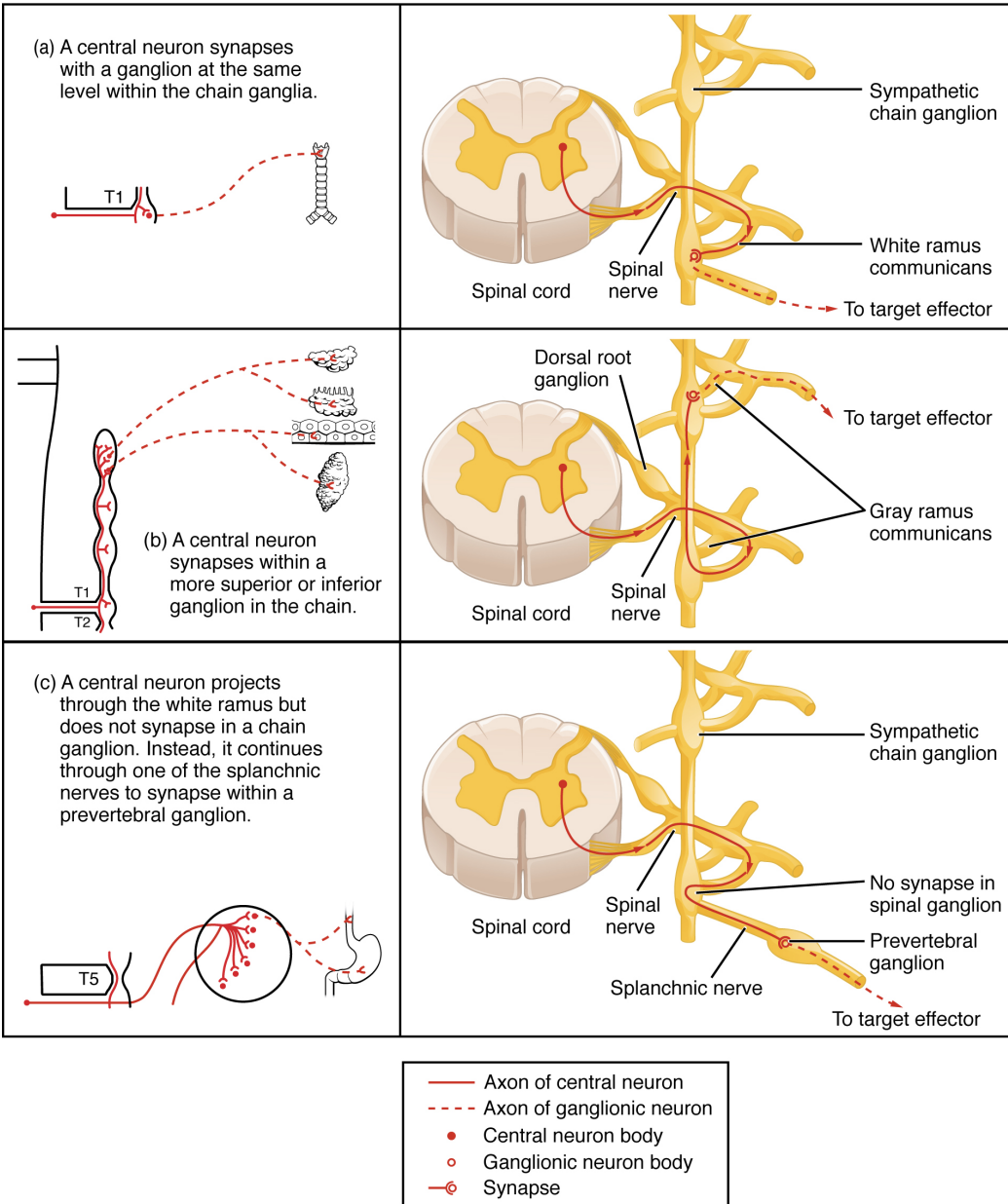
In some cases, the target effectors are located superior or inferior to the spinal segment at which the preganglionic fiber emerges. With respect to the “wiring” involved, the synapse with the ganglionic neuron occurs at chain ganglia superior or inferior to the location of the central neuron. An example of this is spinal nerve T1 that innervates the eye. The spinal nerve tracks up through the chain until it reaches the **superior cervical ganglion**, where it synapses with the postganglionic neuron (see [\[link\]b](#)). The cervical ganglia are referred to as **paravertebral ganglia**, given their location adjacent to prevertebral ganglia in the sympathetic chain.

Not all axons from the central neurons terminate in the chain ganglia. Additional branches from the ventral nerve root continue through the chain and on to one of the collateral ganglia as the **greater splanchnic nerve** or **lesser splanchnic nerve**. For example, the greater splanchnic nerve at the level of T5 synapses with a collateral ganglion outside the chain before

making the connection to the postganglionic nerves that innervate the stomach (see [\[link\]](#)c).

Collateral ganglia, also called **prevertebral ganglia**, are situated anterior to the vertebral column and receive inputs from splanchnic nerves as well as central sympathetic neurons. They are associated with controlling organs in the abdominal cavity, and are also considered part of the enteric nervous system. The three collateral ganglia are the **celiac ganglion**, the **superior mesenteric ganglion**, and the **inferior mesenteric ganglion** (see [\[link\]](#)). The word celiac is derived from the Latin word “coelom,” which refers to a body cavity (in this case, the abdominal cavity), and the word mesenteric refers to the digestive system.

Sympathetic Connections and Chain Ganglia



The axon from a central sympathetic neuron in the spinal cord can project to the periphery in a number of different ways. (a) The fiber can project out to the ganglion at the same level and synapse on a ganglionic neuron. (b) A branch can project to more superior or inferior ganglion in the chain. (c) A branch can project through the white ramus communicans, but not terminate on a ganglionic neuron in the chain. Instead, it projects through one of the splanchnic

nerves to a collateral ganglion or the adrenal medulla (not pictured).

An axon from the central neuron that projects to a sympathetic ganglion is referred to as a **preganglionic fiber** or neuron, and represents the output from the CNS to the ganglion. Because the sympathetic ganglia are adjacent to the vertebral column, preganglionic sympathetic fibers are relatively short, and they are myelinated. A **postganglionic fiber**—the axon from a ganglionic neuron that projects to the target effector—represents the output of a ganglion that directly influences the organ. Compared with the preganglionic fibers, postganglionic sympathetic fibers are long because of the relatively greater distance from the ganglion to the target effector. These fibers are unmyelinated. (Note that the term “postganglionic neuron” may be used to describe the projection from a ganglion to the target. The problem with that usage is that the cell body is in the ganglion, and only the fiber is postganglionic. Typically, the term neuron applies to the entire cell.)

One type of preganglionic sympathetic fiber does not terminate in a ganglion. These are the axons from central sympathetic neurons that project to the **adrenal medulla**, the interior portion of the adrenal gland. These axons are still referred to as preganglionic fibers, but the target is not a ganglion. The adrenal medulla releases signaling molecules into the bloodstream, rather than using axons to communicate with target structures. The cells in the adrenal medulla that are contacted by the preganglionic fibers are called **chromaffin cells**. These cells are neurosecretory cells that develop from the neural crest along with the sympathetic ganglia, reinforcing the idea that the gland is, functionally, a sympathetic ganglion.

The projections of the sympathetic division of the autonomic nervous system diverge widely, resulting in a broad influence of the system throughout the body. As a response to a threat, the sympathetic system would increase heart rate and breathing rate and cause blood flow to the skeletal muscle to increase and blood flow to the digestive system to decrease. Sweat gland secretion should also increase as part of an integrated response. All of those physiological changes are going to be required to occur together to run away from the hunting lioness, or the modern equivalent. This divergence is seen in the branching patterns of

preganglionic sympathetic neurons—a single preganglionic sympathetic neuron may have 10–20 targets. An axon that leaves a central neuron of the lateral horn in the thoracolumbar spinal cord will pass through the white ramus communicans and enter the sympathetic chain, where it will branch toward a variety of targets. At the level of the spinal cord at which the preganglionic sympathetic fiber exits the spinal cord, a branch will synapse on a neuron in the adjacent chain ganglion. Some branches will extend up or down to a different level of the chain ganglia. Other branches will pass through the chain ganglia and project through one of the splanchnic nerves to a collateral ganglion. Finally, some branches may project through the splanchnic nerves to the adrenal medulla. All of these branches mean that one preganglionic neuron can influence different regions of the sympathetic system very broadly, by acting on widely distributed organs.

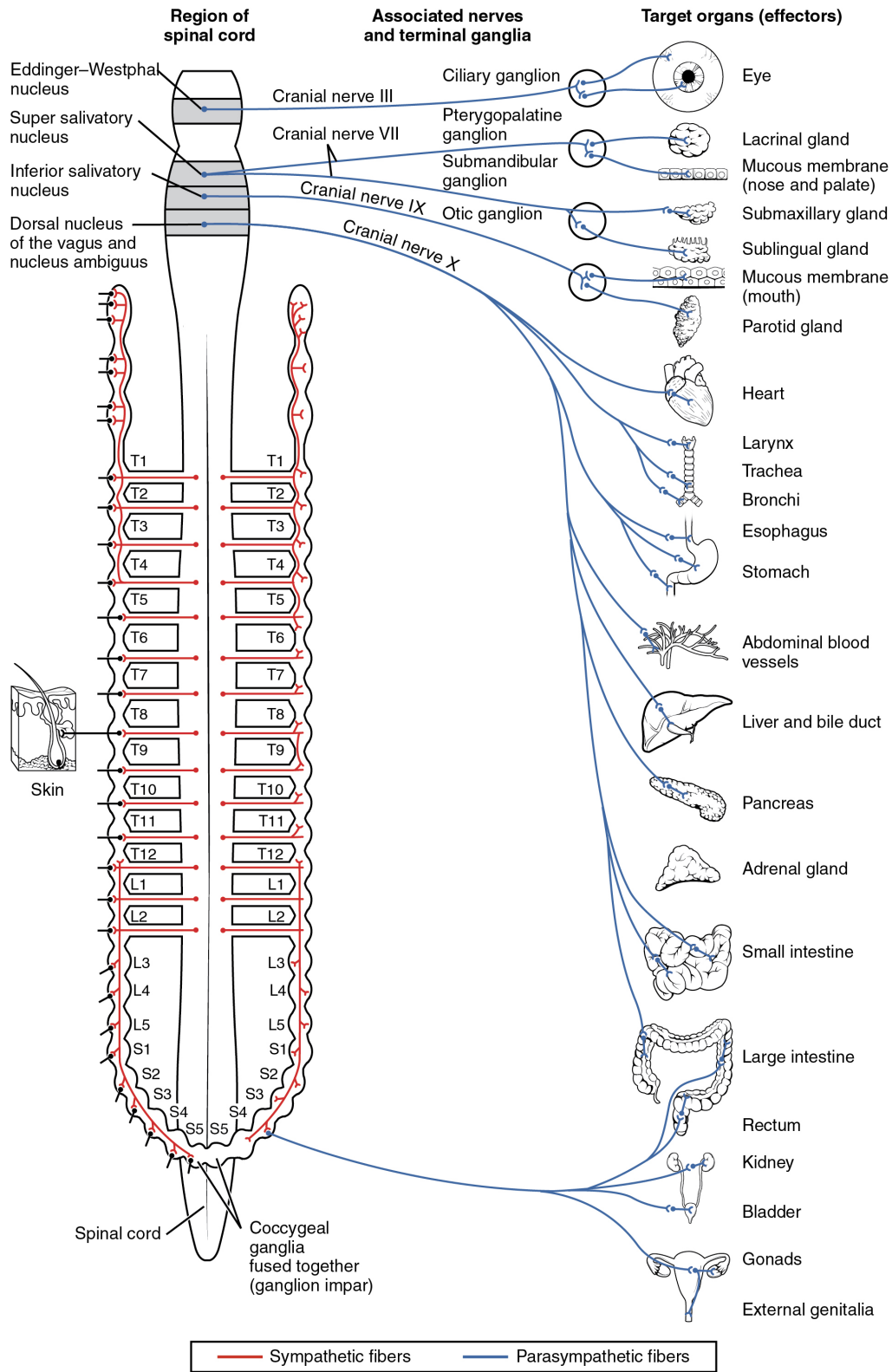
Parasympathetic Division of the Autonomic Nervous System

The parasympathetic division of the autonomic nervous system is named because its central neurons are located on either side of the thoracolumbar region of the spinal cord (para- = “beside” or “near”). The parasympathetic system can also be referred to as the **craniosacral system** (or outflow) because the preganglionic neurons are located in nuclei of the brain stem and the lateral horn of the sacral spinal cord.

The connections, or “circuits,” of the parasympathetic division are similar to the general layout of the sympathetic division with a few specific differences ([\[link\]](#)). The preganglionic fibers from the cranial region travel in cranial nerves, whereas preganglionic fibers from the sacral region travel in spinal nerves. The targets of these fibers are **terminal ganglia**, which are located near—or even within—the target effector. These ganglia are often referred to as **intramural ganglia** when they are found within the walls of the target organ. The postganglionic fiber projects from the terminal ganglia a short distance to the target effector, or to the specific target tissue within the organ. Comparing the relative lengths of axons in the parasympathetic system, the preganglionic fibers are long and the postganglionic fibers are short because the ganglia are close to—and sometimes within—the target effectors.

The cranial component of the parasympathetic system is based in particular nuclei of the brain stem. In the midbrain, the **Edinger–Westphal nucleus** is part of the oculomotor complex, and axons from those neurons travel with the fibers in the oculomotor nerve (cranial nerve III) that innervate the extraocular muscles. The preganglionic parasympathetic fibers within cranial nerve III terminate in the **ciliary ganglion**, which is located in the posterior orbit. The postganglionic parasympathetic fibers then project to the smooth muscle of the iris to control pupillary size. In the upper medulla, the salivatory nuclei contain neurons with axons that project through the facial and glossopharyngeal nerves to ganglia that control salivary glands. Tear production is influenced by parasympathetic fibers in the facial nerve, which activate a ganglion, and ultimately the lacrimal (tear) gland. Neurons in the **dorsal nucleus of the vagus nerve** and the **nucleus ambiguus** project through the vagus nerve (cranial nerve X) to the terminal ganglia of the thoracic and abdominal cavities. Parasympathetic preganglionic fibers primarily influence the heart, bronchi, and esophagus in the thoracic cavity and the stomach, liver, pancreas, gall bladder, and small intestine of the abdominal cavity. The postganglionic fibers from the ganglia activated by the vagus nerve are often incorporated into the structure of the organ, such as the **mesenteric plexus** of the digestive tract organs and the intramural ganglia.

Connections of Parasympathetic Division of the Autonomic Nervous System



Neurons from brain-stem nuclei, or from the lateral horn of

the sacral spinal cord, project to terminal ganglia near or within the various organs of the body. Axons from these ganglionic neurons then project the short distance to those target effectors.

Chemical Signaling in the Autonomic Nervous System

Where an autonomic neuron connects with a target, there is a synapse. The electrical signal of the action potential causes the release of a signaling molecule, which will bind to receptor proteins on the target cell. Synapses of the autonomic system are classified as either **cholinergic**, meaning that **acetylcholine (ACh)** is released, or **adrenergic**, meaning that **norepinephrine** is released. The terms cholinergic and adrenergic refer not only to the signaling molecule that is released but also to the class of receptors that each binds.

The cholinergic system includes two classes of receptor: the **nicotinic receptor** and the **muscarinic receptor**. Both receptor types bind to ACh and cause changes in the target cell. The nicotinic receptor is a **ligand-gated cation channel** and the muscarinic receptor is a **G protein-coupled receptor**. The receptors are named for, and differentiated by, other molecules that bind to them. Whereas nicotine will bind to the nicotinic receptor, and muscarine will bind to the muscarinic receptor, there is no cross-reactivity between the receptors. The situation is similar to locks and keys. Imagine two locks—one for a classroom and the other for an office—that are opened by two separate keys. The classroom key will not open the office door and the office key will not open the classroom door. This is similar to the specificity of nicotine and muscarine for their receptors. However, a master key can open multiple locks, such as a master key for the Biology Department that opens both the classroom and the office doors. This is similar to ACh that binds to both types of receptors. The molecules that define these receptors are not crucial—they are simply tools for researchers to use in the laboratory. These molecules are **exogenous**, meaning that they are made outside of the human body, so a researcher can

use them without any confounding **endogenous** results (results caused by the molecules produced in the body).

The adrenergic system also has two types of receptors, named the **alpha (α)-adrenergic receptor** and **beta (β)-adrenergic receptor**. Unlike cholinergic receptors, these receptor types are not classified by which drugs can bind to them. All of them are G protein–coupled receptors. There are three types of α -adrenergic receptors, termed α_1 , α_2 , and α_3 , and there are two types of β -adrenergic receptors, termed β_1 and β_2 . An additional aspect of the adrenergic system is that there is a second signaling molecule called **epinephrine**. The chemical difference between norepinephrine and epinephrine is the addition of a methyl group (CH_3) in epinephrine. The prefix “nor-” actually refers to this chemical difference, in which a methyl group is missing.

The term adrenergic should remind you of the word adrenaline, which is associated with the fight-or-flight response described at the beginning of the chapter. Adrenaline and epinephrine are two names for the same molecule. The adrenal gland (in Latin, ad- = “on top of”; renal = “kidney”) secretes adrenaline. The ending “-ine” refers to the chemical being derived, or extracted, from the adrenal gland. A similar construction from Greek instead of Latin results in the word epinephrine (epi- = “above”; nephro- = “kidney”). In scientific usage, epinephrine is preferred in the United States, whereas adrenaline is preferred in Great Britain, because “adrenalin” was once a registered, proprietary drug name in the United States. Though the drug is no longer sold, the convention of referring to this molecule by the two different names persists. Similarly, norepinephrine and noradrenaline are two names for the same molecule.

Having understood the cholinergic and adrenergic systems, their role in the autonomic system is relatively simple to understand. All preganglionic fibers, both sympathetic and parasympathetic, release ACh. All ganglionic neurons—the targets of these preganglionic fibers—have nicotinic receptors in their cell membranes. The nicotinic receptor is a ligand-gated cation channel that results in depolarization of the postsynaptic membrane. The postganglionic parasympathetic fibers also release ACh, but the receptors on their targets are muscarinic receptors, which are G protein–coupled

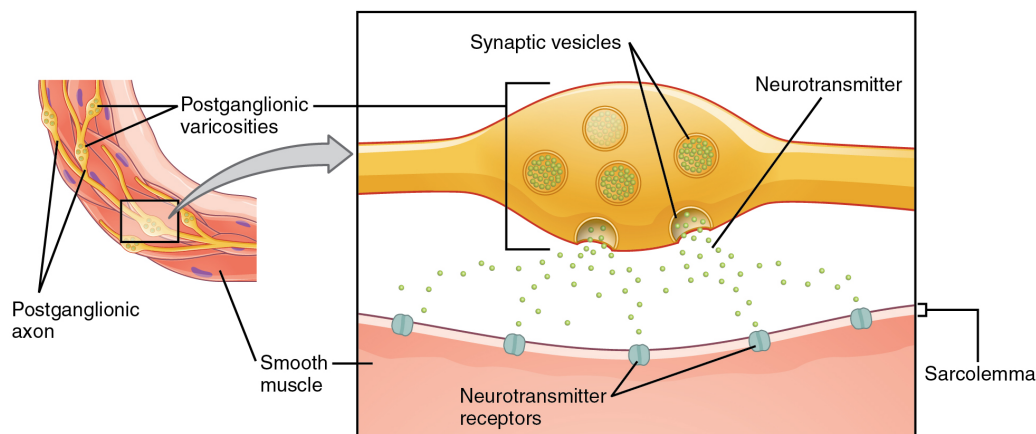
receptors and do not exclusively cause depolarization of the postsynaptic membrane. Postganglionic sympathetic fibers release norepinephrine, except for fibers that project to sweat glands and to blood vessels associated with skeletal muscles, which release ACh ([\[link\]](#)).

Autonomic System Signaling Molecules		
	Sympathetic	Parasympathetic
Preganglionic	Acetylcholine → nicotinic receptor	Acetylcholine → nicotinic receptor
Postganglionic	Norepinephrine → α - or β -adrenergic receptors Acetylcholine → muscarinic receptor (associated with sweat glands and the blood vessels associated with skeletal muscles only)	Acetylcholine → muscarinic receptor

Signaling molecules can belong to two broad groups. Neurotransmitters are released at synapses, whereas hormones are released into the bloodstream. These are simplistic definitions, but they can help to clarify this point. Acetylcholine can be considered a neurotransmitter because it is released by axons at synapses. The adrenergic system, however, presents a challenge. Postganglionic sympathetic fibers release norepinephrine, which can be considered a neurotransmitter. But the adrenal medulla releases epinephrine and norepinephrine into circulation, so they should be considered hormones.

What are referred to here as synapses may not fit the strictest definition of synapse. Some sources will refer to the connection between a postganglionic fiber and a target effector as neuroeffector junctions; neurotransmitters, as defined above, would be called neuromodulators. The structure of postganglionic connections are not the typical synaptic end bulb that is found at the neuromuscular junction, but rather are chains of swellings along the length of a postganglionic fiber called a **varicosity** ([link](#)).

Autonomic Varicosities



The connection between autonomic fibers and target effectors is not the same as the typical synapse, such as the neuromuscular junction. Instead of a synaptic end bulb, a neurotransmitter is released from swellings along the length of a fiber that makes an extended network of connections in the target effector.

Note:

Everyday Connections

Fight or Flight? What About Fright and Freeze?

The original usage of the epithet “fight or flight” comes from a scientist named Walter Cannon who worked at Harvard in 1915. The concept of homeostasis and the functioning of the sympathetic system had been

introduced in France in the previous century. Cannon expanded the idea, and introduced the idea that an animal responds to a threat by preparing to stand and fight or run away. The nature of this response was thoroughly explained in a book on the physiology of pain, hunger, fear, and rage. When students learn about the sympathetic system and the fight-or-flight response, they often stop and wonder about other responses. If you were faced with a lioness running toward you as pictured at the beginning of this chapter, would you run or would you stand your ground? Some people would say that they would freeze and not know what to do. So isn't there really more to what the autonomic system does than fight, flight, rest, or digest. What about fear and paralysis in the face of a threat? The common epithet of "fight or flight" is being enlarged to be "fight, flight, or fright" or even "fight, flight, fright, or freeze." Cannon's original contribution was a catchy phrase to express some of what the nervous system does in response to a threat, but it is incomplete. The sympathetic system is responsible for the physiological responses to emotional states. The name "sympathetic" can be said to mean that (sym- = "together"; -pathos = "pain," "suffering," or "emotion").

Note:



Watch this [video](#) to learn more about the nervous system. As described in this video, the nervous system has a way to deal with threats and stress that is separate from the conscious control of the somatic nervous system. The system comes from a time when threats were about survival, but in the modern age, these responses become part of stress and anxiety. This video describes how the autonomic system is only part of the response to threats, or stressors. What other organ system gets involved, and what part of the

brain coordinates the two systems for the entire response, including epinephrine (adrenaline) and cortisol?

Chapter Review

The primary responsibilities of the autonomic nervous system are to regulate homeostatic mechanisms in the body, which is also part of what the endocrine system does. The key to understanding the autonomic system is to explore the response pathways—the output of the nervous system. The way we respond to the world around us, to manage the internal environment on the basis of the external environment, is divided between two parts of the autonomic nervous system. The sympathetic division responds to threats and produces a readiness to confront the threat or to run away: the fight-or-flight response. The parasympathetic division plays the opposite role. When the external environment does not present any immediate danger, a restful mode descends on the body, and the digestive system is more active.

The sympathetic output of the nervous system originates out of the lateral horn of the thoracolumbar spinal cord. An axon from one of these central neurons projects by way of the ventral spinal nerve root and spinal nerve to a sympathetic ganglion, either in the sympathetic chain ganglia or one of the collateral locations, where it synapses on a ganglionic neuron. These preganglionic fibers release ACh, which excites the ganglionic neuron through the nicotinic receptor. The axon from the ganglionic neuron—the postganglionic fiber—then projects to a target effector where it will release norepinephrine to bind to an adrenergic receptor, causing a change in the physiology of that organ in keeping with the broad, divergent sympathetic response. The postganglionic connections to sweat glands in the skin and blood vessels supplying skeletal muscle are, however, exceptions; those fibers release ACh onto muscarinic receptors. The sympathetic system has a specialized preganglionic connection to the adrenal medulla that causes epinephrine and norepinephrine to be released into the bloodstream rather than exciting a neuron that contacts an organ directly. This hormonal component means that the sympathetic chemical signal can spread throughout the body very quickly and affect many organ systems at once.

The parasympathetic output is based in the brain stem and sacral spinal cord. Neurons from particular nuclei in the brain stem or from the lateral horn of the sacral spinal cord (preganglionic neurons) project to terminal (intramural) ganglia located close to or within the wall of target effectors. These preganglionic fibers also release ACh onto nicotinic receptors to excite the ganglionic neurons. The postganglionic fibers then contact the target tissues within the organ to release ACh, which binds to muscarinic receptors to induce rest-and-digest responses.

Signaling molecules utilized by the autonomic nervous system are released from axons and can be considered as either neurotransmitters (when they directly interact with the effector) or as hormones (when they are released into the bloodstream). The same molecule, such as norepinephrine, could be considered either a neurotransmitter or a hormone on the basis of whether it is released from a postganglionic sympathetic axon or from the adrenal gland. The synapses in the autonomic system are not always the typical type of connection first described in the neuromuscular junction. Instead of having synaptic end bulbs at the very end of an axonal fiber, they may have swellings—called varicosities—along the length of a fiber so that it makes a network of connections within the target tissue.

Interactive Link Questions

Exercise:

Problem:

Watch this [video](#) to learn more about adrenaline and the fight-or-flight response. When someone is said to have a rush of adrenaline, the image of bungee jumpers or skydivers usually comes to mind. But adrenaline, also known as epinephrine, is an important chemical in coordinating the body's fight-or-flight response. In this video, you look inside the physiology of the fight-or-flight response, as envisioned for a firefighter. His body's reaction is the result of the sympathetic division of the autonomic nervous system causing system-wide changes as it prepares for extreme responses. What two changes does adrenaline bring about to help the skeletal muscle response?

Solution:

The heart rate increases to send more blood to the muscles, and the liver releases stored glucose to fuel the muscles.

Exercise:**Problem:**

Watch this [video](#) to learn more about the nervous system. As described in this video, the nervous system has a way to deal with threats and stress that is separate from the conscious control of the somatic nervous system. The system comes from a time when threats were about survival, but in the modern age, these responses become part of stress and anxiety. This video describes how the autonomic system is only part of the response to threats, or stressors. What other organ system gets involved, and what part of the brain coordinates the two systems for the entire response, including epinephrine (adrenaline) and cortisol?

Solution:

The endocrine system is also responsible for responses to stress in our lives. The hypothalamus coordinates the autonomic response through projections into the spinal cord and through influence over the pituitary gland, the effective center of the endocrine system.

Review Questions**Exercise:****Problem:**

Which of these physiological changes would *not* be considered part of the sympathetic fight-or-flight response?

- a. increased heart rate
- b. increased sweating

- c. dilated pupils
 - d. increased stomach motility
-

Solution:

D

Exercise:

Problem: Which type of fiber could be considered the longest?

- a. preganglionic parasympathetic
 - b. preganglionic sympathetic
 - c. postganglionic parasympathetic
 - d. postganglionic sympathetic
-

Solution:

A

Exercise:

Problem:

Which signaling molecule is *most likely* responsible for an increase in digestive activity?

- a. epinephrine
 - b. norepinephrine
 - c. acetylcholine
 - d. adrenaline
-

Solution:

C

Exercise:

Problem:

Which of these cranial nerves contains preganglionic parasympathetic fibers?

- a. optic, CN II
- b. facial, CN VII
- c. trigeminal, CN V
- d. hypoglossal, CN XII

Solution:

B

Exercise:**Problem:**

Which of the following is *not* a target of a sympathetic preganglionic fiber?

- a. intermural ganglion
- b. collateral ganglion
- c. adrenal gland
- d. chain ganglion

Solution:

A

Critical Thinking Questions**Exercise:**

Problem:

In the context of a lioness hunting on the savannah, why would the sympathetic system *not* activate the digestive system?

Solution:

Whereas energy is needed for running away from the threat, blood needs to be sent to the skeletal muscles for oxygen supply. The additional fuel, in the form of carbohydrates, probably wouldn't improve the ability to escape the threat as much as the diversion of oxygen-rich blood would hinder it.

Exercise:**Problem:**

A target effector, such as the heart, receives input from the sympathetic and parasympathetic systems. What is the actual difference between the sympathetic and parasympathetic divisions at the level of those connections (i.e., at the synapse)?

Solution:

The postganglionic sympathetic fiber releases norepinephrine, whereas the postganglionic parasympathetic fiber releases acetylcholine. Specific locations in the heart have adrenergic receptors and muscarinic receptors. Which receptors are bound is the signal that determines how the heart responds.

Glossary

alpha (α)-adrenergic receptor

one of the receptors to which epinephrine and norepinephrine bind, which comes in three subtypes: α_1 , α_2 , and α_3

acetylcholine (ACh)

neurotransmitter that binds at a motor end-plate to trigger depolarization

adrenal medulla

interior portion of the adrenal (or suprarenal) gland that releases epinephrine and norepinephrine into the bloodstream as hormones

adrenergic

synapse where norepinephrine is released, which binds to α - or β -adrenergic receptors

beta (β)-adrenergic receptor

one of the receptors to which epinephrine and norepinephrine bind, which comes in two subtypes: β_1 and β_2

celiac ganglion

one of the collateral ganglia of the sympathetic system that projects to the digestive system

central neuron

specifically referring to the cell body of a neuron in the autonomic system that is located in the central nervous system, specifically the lateral horn of the spinal cord or a brain stem nucleus

cholinergic

synapse at which acetylcholine is released and binds to the nicotinic or muscarinic receptor

chromaffin cells

neuroendocrine cells of the adrenal medulla that release epinephrine and norepinephrine into the bloodstream as part of sympathetic system activity

ciliary ganglion

one of the terminal ganglia of the parasympathetic system, located in the posterior orbit, axons from which project to the iris

collateral ganglia

ganglia outside of the sympathetic chain that are targets of sympathetic preganglionic fibers, which are the celiac, inferior mesenteric, and superior mesenteric ganglia

craniosacral system

alternate name for the parasympathetic division of the autonomic nervous system that is based on the anatomical location of central neurons in brain-stem nuclei and the lateral horn of the sacral spinal cord; also referred to as craniosacral outflow

dorsal nucleus of the vagus nerve

location of parasympathetic neurons that project through the vagus nerve to terminal ganglia in the thoracic and abdominal cavities

Eddinger–Westphal nucleus

location of parasympathetic neurons that project to the ciliary ganglion

endogenous

describes substance made in the human body

epinephrine

signaling molecule released from the adrenal medulla into the bloodstream as part of the sympathetic response

exogenous

describes substance made outside of the human body

fight-or-flight response

set of responses induced by sympathetic activity that lead to either fleeing a threat or standing up to it, which in the modern world is often associated with anxious feelings

G protein–coupled receptor

membrane protein complex that consists of a receptor protein that binds to a signaling molecule—a G protein—that is activated by that binding and in turn activates an effector protein (enzyme) that creates a second-messenger molecule in the cytoplasm of the target cell

ganglionic neuron

specifically refers to the cell body of a neuron in the autonomic system that is located in a ganglion

gray rami communicantes

(singular = ramus communicans) unmyelinated structures that provide a short connection from a sympathetic chain ganglion to the spinal nerve that contains the postganglionic sympathetic fiber

greater splanchnic nerve

nerve that contains fibers of the central sympathetic neurons that do not synapse in the chain ganglia but project onto the celiac ganglion

inferior mesenteric ganglion

one of the collateral ganglia of the sympathetic system that projects to the digestive system

intramural ganglia

terminal ganglia of the parasympathetic system that are found within the walls of the target effector

lesser splanchnic nerve

nerve that contains fibers of the central sympathetic neurons that do not synapse in the chain ganglia but project onto the inferior mesenteric ganglion

ligand-gated cation channel

ion channel, such as the nicotinic receptor, that is specific to positively charged ions and opens when a molecule such as a neurotransmitter binds to it

mesenteric plexus

nervous tissue within the wall of the digestive tract that contains neurons that are the targets of autonomic preganglionic fibers and that project to the smooth muscle and glandular tissues in the digestive organ

muscarinic receptor

type of acetylcholine receptor protein that is characterized by also binding to muscarine and is a metabotropic receptor

nicotinic receptor

type of acetylcholine receptor protein that is characterized by also binding to nicotine and is an ionotropic receptor

norepinephrine

signaling molecule released as a neurotransmitter by most postganglionic sympathetic fibers as part of the sympathetic response, or as a hormone into the bloodstream from the adrenal medulla

nucleus ambiguus

brain-stem nucleus that contains neurons that project through the vagus nerve to terminal ganglia in the thoracic cavity; specifically associated with the heart

parasympathetic division

division of the autonomic nervous system responsible for restful and digestive functions

paravertebral ganglia

autonomic ganglia superior to the sympathetic chain ganglia

postganglionic fiber

axon from a ganglionic neuron in the autonomic nervous system that projects to and synapses with the target effector; sometimes referred to as a postganglionic neuron

preganglionic fiber

axon from a central neuron in the autonomic nervous system that projects to and synapses with a ganglionic neuron; sometimes referred to as a preganglionic neuron

prevertebral ganglia

autonomic ganglia that are anterior to the vertebral column and functionally related to the sympathetic chain ganglia

rest and digest

set of functions associated with the parasympathetic system that lead to restful actions and digestion

superior cervical ganglion

one of the paravertebral ganglia of the sympathetic system that projects to the head

superior mesenteric ganglion

one of the collateral ganglia of the sympathetic system that projects to the digestive system

sympathetic chain ganglia

series of ganglia adjacent to the vertebral column that receive input from central sympathetic neurons

sympathetic division

division of the autonomic nervous system associated with the fight-or-flight response

target effector

organ, tissue, or gland that will respond to the control of an autonomic or somatic or endocrine signal

terminal ganglia

ganglia of the parasympathetic division of the autonomic system, which are located near or within the target effector, the latter also known as intramural ganglia

thoracolumbar system

alternate name for the sympathetic division of the autonomic nervous system that is based on the anatomical location of central neurons in the lateral horn of the thoracic and upper lumbar spinal cord

varicosity

structure of some autonomic connections that is not a typical synaptic end bulb, but a string of swellings along the length of a fiber that makes a network of connections with the target effector

white rami communicantes

(singular = ramus communicans) myelinated structures that provide a short connection from a sympathetic chain ganglion to the spinal nerve that contains the preganglionic sympathetic fiber

Autonomic Reflexes and Homeostasis

By the end of this section, you will be able to:

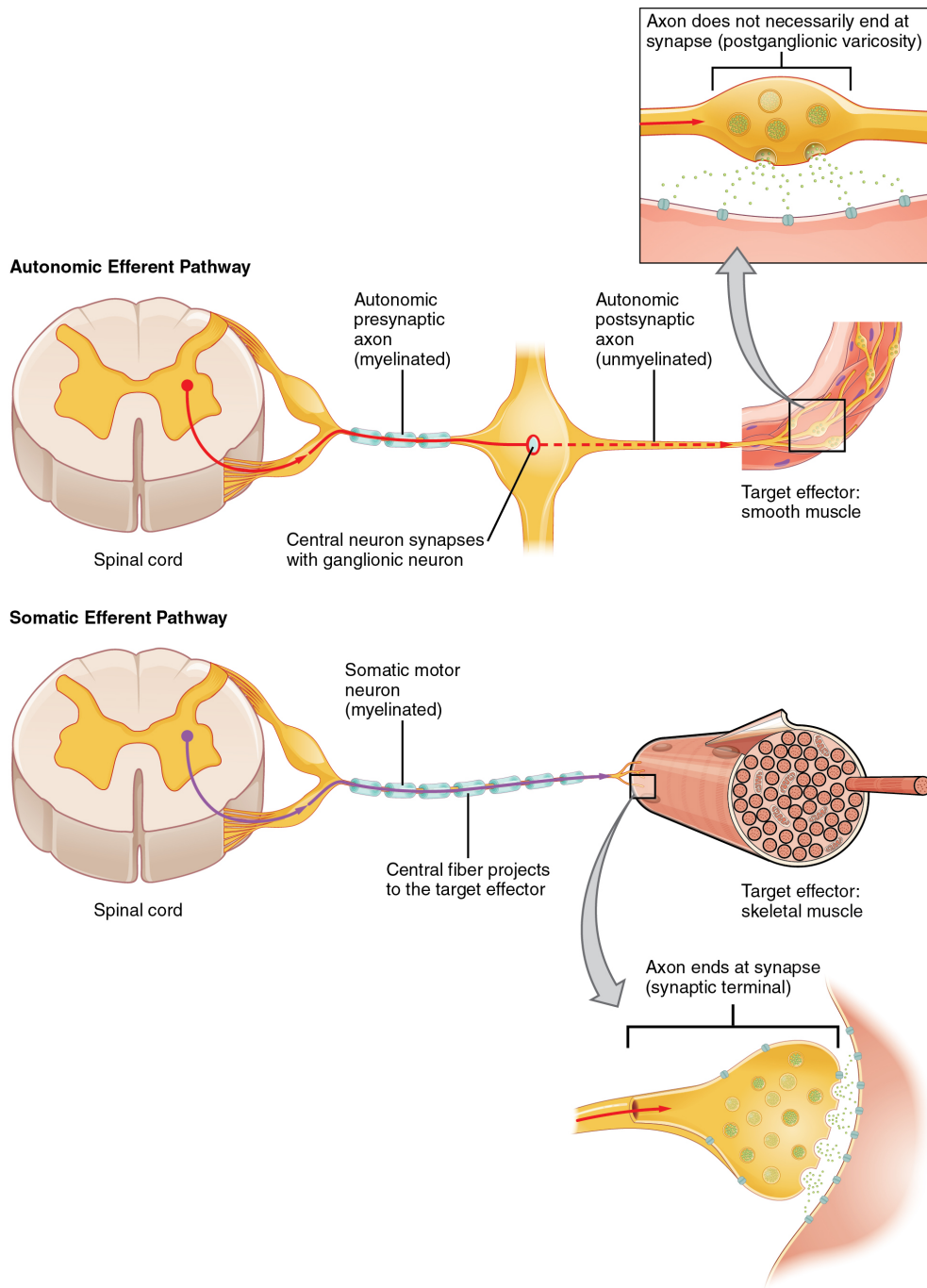
- Compare the structure of somatic and autonomic reflex arcs
- Explain the differences in sympathetic and parasympathetic reflexes
- Differentiate between short and long reflexes
- Determine the effect of the autonomic nervous system on the regulation of the various organ systems on the basis of the signaling molecules involved
- Describe the effects of drugs that affect autonomic function

The autonomic nervous system regulates organ systems through circuits that resemble the reflexes described in the somatic nervous system. The main difference between the somatic and autonomic systems is in what target tissues are effectors. Somatic responses are solely based on skeletal muscle contraction. The autonomic system, however, targets cardiac and smooth muscle, as well as glandular tissue. Whereas the basic circuit is a **reflex arc**, there are differences in the structure of those reflexes for the somatic and autonomic systems.

The Structure of Reflexes

One difference between a **somatic reflex**, such as the withdrawal reflex, and a **visceral reflex**, which is an autonomic reflex, is in the **efferent branch**. The output of a somatic reflex is the lower motor neuron in the ventral horn of the spinal cord that projects directly to a skeletal muscle to cause its contraction. The output of a visceral reflex is a two-step pathway starting with the preganglionic fiber emerging from a lateral horn neuron in the spinal cord, or a cranial nucleus neuron in the brain stem, to a ganglion—followed by the postganglionic fiber projecting to a target effector. The other part of a reflex, the **afferent branch**, is often the same between the two systems. Sensory neurons receiving input from the periphery—with cell bodies in the sensory ganglia, either of a cranial nerve or a dorsal root ganglion adjacent to the spinal cord—project into the CNS to initiate the reflex ([\[link\]](#)). The Latin root “effere” means “to carry.” Adding the prefix “ef-” suggests the meaning “to carry away,” whereas adding the prefix “af-” suggests “to carry toward or inward.”

Comparison of Somatic and Visceral Reflexes



The afferent inputs to somatic and visceral reflexes are essentially the same, whereas the efferent branches are different. Somatic reflexes, for instance, involve a direct connection from the ventral horn of the spinal cord to the skeletal muscle. Visceral reflexes involve a projection

from the central neuron to a ganglion, followed by a second projection from the ganglion to the target effector.

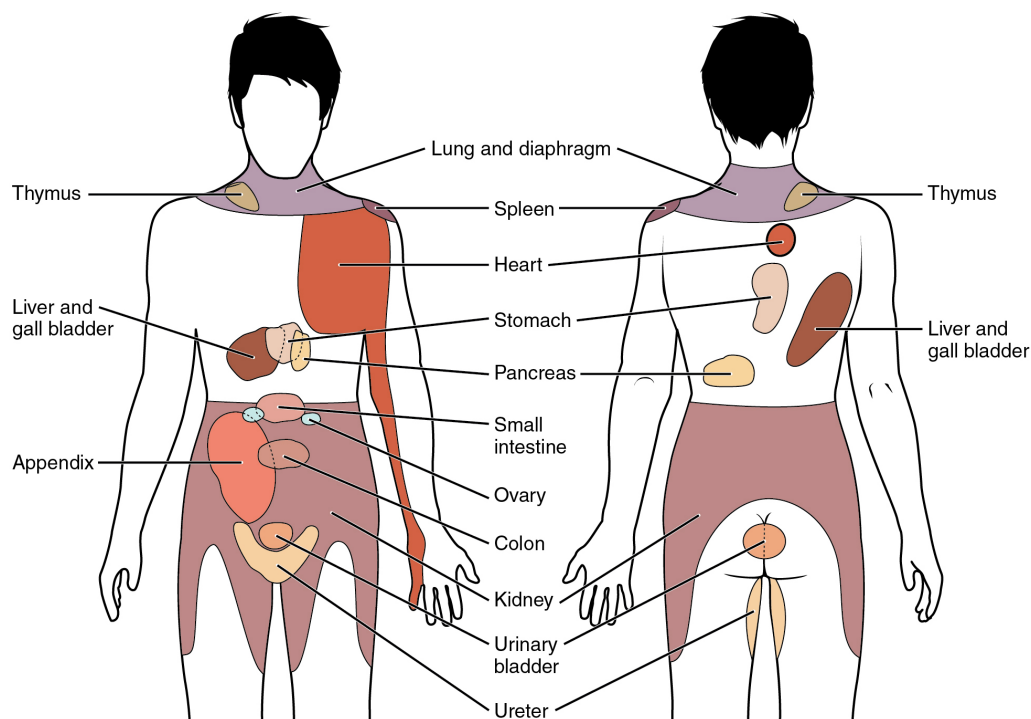
Afferent Branch

The afferent branch of a reflex arc does differ between somatic and visceral reflexes in some instances. Many of the inputs to visceral reflexes are from special or somatic senses, but particular senses are associated with the viscera that are not part of the conscious perception of the environment through the somatic nervous system. For example, there is a specific type of mechanoreceptor, called a **baroreceptor**, in the walls of the aorta and carotid sinuses that senses the stretch of those organs when blood volume or pressure increases. You do not have a conscious perception of having high blood pressure, but that is an important afferent branch of the cardiovascular and, particularly, vasomotor reflexes. The sensory neuron is essentially the same as any other general sensory neuron. The baroreceptor apparatus is part of the ending of a unipolar neuron that has a cell body in a sensory ganglion. The baroreceptors from the carotid arteries have axons in the glossopharyngeal nerve, and those from the aorta have axons in the vagus nerve.

Though visceral senses are not primarily a part of conscious perception, those sensations sometimes make it to conscious awareness. If a visceral sense is strong enough, it will be perceived. The sensory homunculus—the representation of the body in the primary somatosensory cortex—only has a small region allotted for the perception of internal stimuli. If you swallow a large bolus of food, for instance, you will probably feel the lump of that food as it pushes through your esophagus, or even if your stomach is distended after a large meal. If you inhale especially cold air, you can feel it as it enters your larynx and trachea. These sensations are not the same as feeling high blood pressure or blood sugar levels.

When particularly strong visceral sensations rise to the level of conscious perception, the sensations are often felt in unexpected places. For example, strong visceral sensations of the heart will be felt as pain in the left shoulder and left arm. This irregular pattern of projection of conscious perception of visceral sensations is called **referred pain**. Depending on the organ system affected, the referred pain will project to different areas of the body ([link](#)). The location of referred pain is not random, but a definitive explanation of the mechanism has not been established. The most broadly accepted theory for this phenomenon is that the visceral sensory fibers enter into the same level of the spinal cord as the somatosensory fibers of the referred pain location. By this explanation, the visceral sensory fibers from the mediastinal region, where the heart is located, would enter the spinal cord at the same level as the spinal nerves from the shoulder and arm, so the brain misinterprets the sensations from the mediastinal region as being from the axillary and brachial regions. Projections from the medial and inferior divisions of the cervical ganglia do enter the spinal cord at the middle to lower cervical levels, which is where the somatosensory fibers enter.

Referred Pain Chart



Conscious perception of visceral sensations map to specific regions of the body, as shown in this chart. Some sensations

are felt locally, whereas others are perceived as affecting areas that are quite distant from the involved organ.

Note:

Disorders of the...

Nervous System: Kehr's Sign

Kehr's sign is the presentation of pain in the left shoulder, chest, and neck regions following rupture of the spleen. The spleen is in the upper-left abdominopelvic quadrant, but the pain is more in the shoulder and neck. How can this be? The sympathetic fibers connected to the spleen are from the celiac ganglion, which would be from the mid-thoracic to lower thoracic region whereas parasympathetic fibers are found in the vagus nerve, which connects in the medulla of the brain stem. However, the neck and shoulder would connect to the spinal cord at the mid-cervical level of the spinal cord. These connections do not fit with the expected correspondence of visceral and somatosensory fibers entering at the same level of the spinal cord.

The incorrect assumption would be that the visceral sensations are coming from the spleen directly. In fact, the visceral fibers are coming from the diaphragm. The nerve connecting to the diaphragm takes a special route. The phrenic nerve is connected to the spinal cord at cervical levels 3 to 5. The motor fibers that make up this nerve are responsible for the muscle contractions that drive ventilation. These fibers have left the spinal cord to enter the phrenic nerve, meaning that spinal cord damage below the mid-cervical level is not fatal by making ventilation impossible. Therefore, the visceral fibers from the diaphragm enter the spinal cord at the same level as the somatosensory fibers from the neck and shoulder.

The diaphragm plays a role in Kehr's sign because the spleen is just inferior to the diaphragm in the upper-left quadrant of the abdominopelvic cavity. When the spleen ruptures, blood spills into this region. The accumulating hemorrhage then puts pressure on the diaphragm. The visceral sensation is actually in the diaphragm, so the referred pain is in a region of the body that corresponds to the diaphragm, not the spleen.

Efferent Branch

The efferent branch of the visceral reflex arc begins with the projection from the central neuron along the preganglionic fiber. This fiber then makes a synapse on the ganglionic neuron that projects to the target effector.

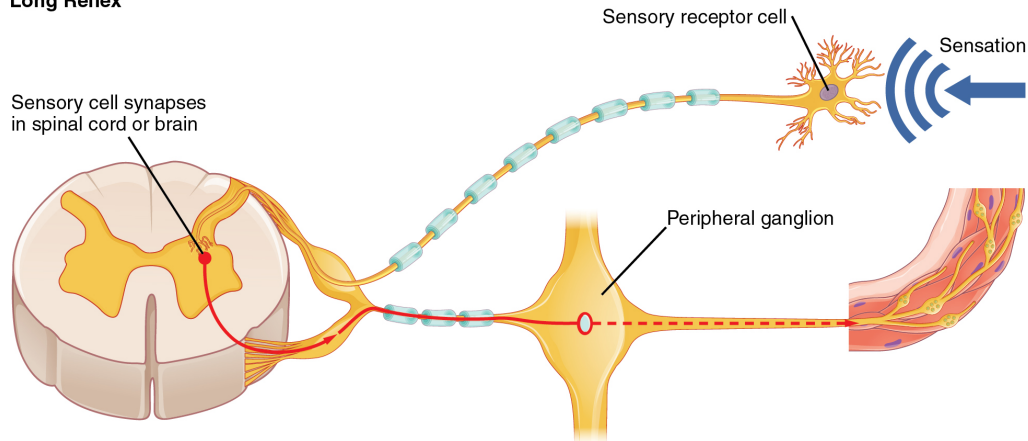
The effector organs that are the targets of the autonomic system range from the iris and ciliary body of the eye to the urinary bladder and reproductive organs. The thoracolumbar output, through the various sympathetic ganglia, reaches all of these organs. The cranial component of the parasympathetic system projects from the eye to part of the intestines. The sacral component picks up with the majority of the large intestine and the pelvic organs of the urinary and reproductive systems.

Short and Long Reflexes

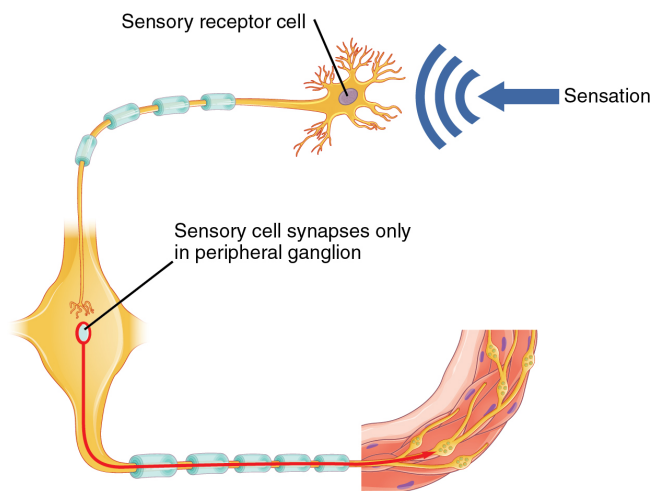
Somatic reflexes involve sensory neurons that connect sensory receptors to the CNS and motor neurons that project back out to the skeletal muscles. Visceral reflexes that involve the thoracolumbar or craniosacral systems share similar connections. However, there are reflexes that do not need to involve any CNS components. A **long reflex** has afferent branches that enter the spinal cord or brain and involve the efferent branches, as previously explained. A **short reflex** is completely peripheral and only involves the local integration of sensory input with motor output ([\[link\]](#)).

Short and Long Reflexes

Long Reflex



Short Reflex



Sensory input can stimulate either a short or a long reflex.

A sensory neuron can project to the CNS or to an autonomic ganglion. The short reflex involves the direct stimulation of a postganglionic fiber by the sensory neuron, whereas the long reflex involves integration in the spinal cord or brain.

The difference between short and long reflexes is in the involvement of the CNS. Somatic reflexes always involve the CNS, even in a monosynaptic reflex in which the sensory neuron directly activates the motor neuron. That synapse is in the spinal cord or brain stem, so it has to involve the CNS. However, in the autonomic system there is the possibility that the CNS is

not involved. Because the efferent branch of a visceral reflex involves two neurons—the central neuron and the ganglionic neuron—a “short circuit” can be possible. If a sensory neuron projects directly to the ganglionic neuron and causes it to activate the effector target, then the CNS is not involved.

A division of the nervous system that is related to the autonomic nervous system is the enteric nervous system. The word enteric refers to the digestive organs, so this represents the nervous tissue that is part of the digestive system. There are a few myenteric plexuses in which the nervous tissue in the wall of the digestive tract organs can directly influence digestive function. If stretch receptors in the stomach are activated by the filling and distension of the stomach, a short reflex will directly activate the smooth muscle fibers of the stomach wall to increase motility to digest the excessive food in the stomach. No CNS involvement is needed because the stretch receptor is directly activating a neuron in the wall of the stomach that causes the smooth muscle to contract. That neuron, connected to the smooth muscle, is a postganglionic parasympathetic neuron that can be controlled by a fiber found in the vagus nerve.

Note:



Read this [article](#) to learn about a teenager who experiences a series of spells that suggest a stroke. He undergoes endless tests and seeks input from multiple doctors. In the end, one expert, one question, and a simple blood pressure cuff answers the question. Why would the heart have to beat faster when the teenager changes his body position from lying down to sitting, and then to standing?

Balance in Competing Autonomic Reflex Arcs

The autonomic nervous system is important for homeostasis because its two divisions compete at the target effector. The balance of homeostasis is attributable to the competing inputs from the sympathetic and parasympathetic divisions (dual innervation). At the level of the target effector, the signal of which system is sending the message is strictly chemical. A signaling molecule binds to a receptor that causes changes in the target cell, which in turn causes the tissue or organ to respond to the changing conditions of the body.

Competing Neurotransmitters

The postganglionic fibers of the sympathetic and parasympathetic divisions both release neurotransmitters that bind to receptors on their targets. Postganglionic sympathetic fibers release norepinephrine, with a minor exception, whereas postganglionic parasympathetic fibers release ACh. For any given target, the difference in which division of the autonomic nervous system is exerting control is just in what chemical binds to its receptors. The target cells will have adrenergic and muscarinic receptors. If norepinephrine is released, it will bind to the adrenergic receptors present on the target cell, and if ACh is released, it will bind to the muscarinic receptors on the target cell.

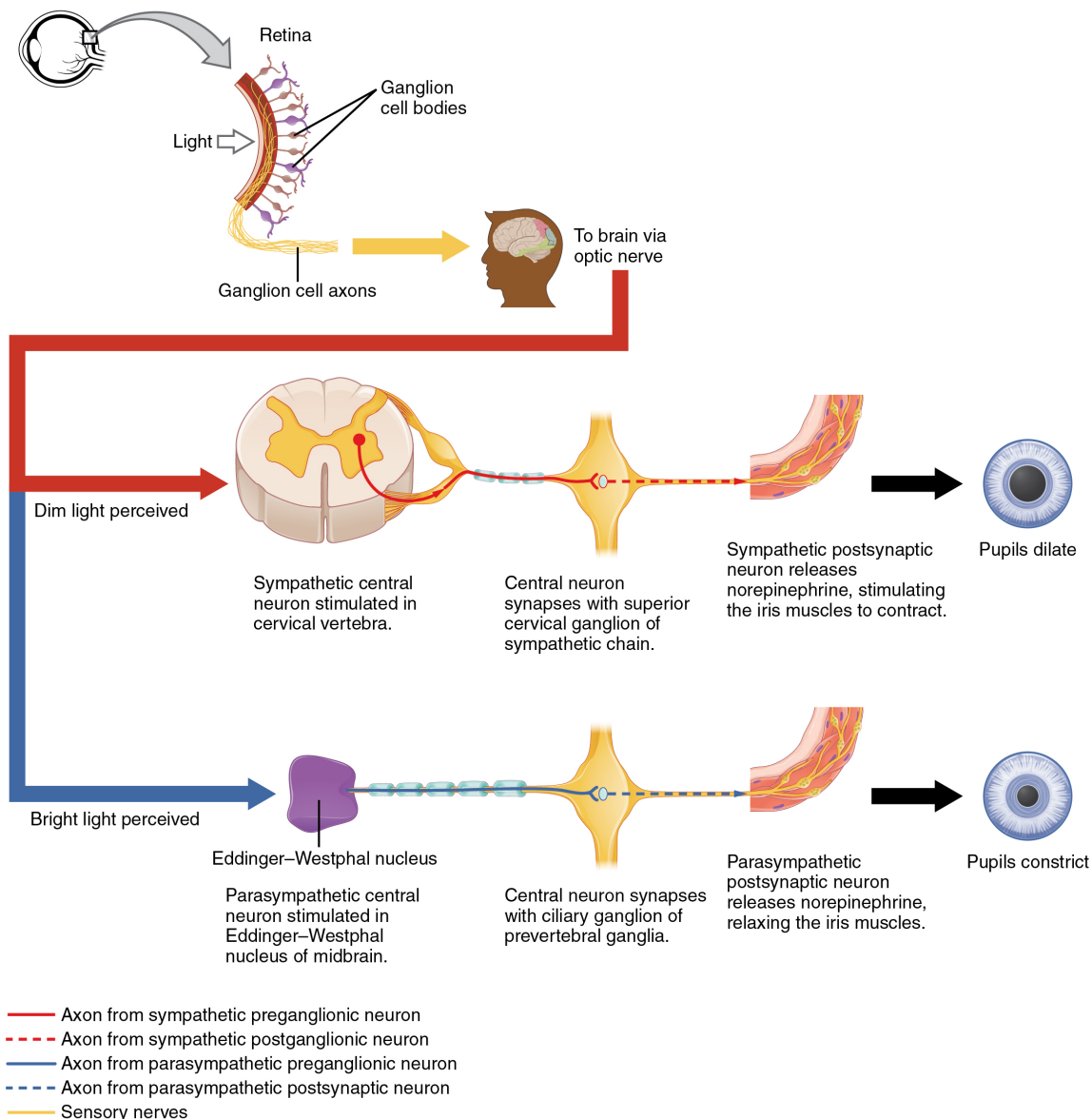
In the sympathetic system, there are exceptions to this pattern of dual innervation. The postganglionic sympathetic fibers that contact the blood vessels within skeletal muscle and that contact sweat glands do not release norepinephrine, they release ACh. This does not create any problem because there is no parasympathetic input to the sweat glands. Sweat glands have muscarinic receptors and produce and secrete sweat in response to the presence of ACh.

At most of the other targets of the autonomic system, the effector response is based on which neurotransmitter is released and what receptor is present. For example, regions of the heart that establish heart rate are contacted by postganglionic fibers from both systems. If norepinephrine is released onto

those cells, it binds to an adrenergic receptor that causes the cells to depolarize faster, and the heart rate increases. If ACh is released onto those cells, it binds to a muscarinic receptor that causes the cells to hyperpolarize so that they cannot reach threshold as easily, and the heart rate slows. Without this parasympathetic input, the heart would work at a rate of approximately 100 beats per minute (bpm). The sympathetic system speeds that up, as it would during exercise, to 120–140 bpm, for example. The parasympathetic system slows it down to the resting heart rate of 60–80 bpm.

Another example is in the control of pupillary size ([link](#)). The afferent branch responds to light hitting the retina. Photoreceptors are activated, and the signal is transferred to the retinal ganglion cells that send an action potential along the optic nerve into the diencephalon. If light levels are low, the sympathetic system sends a signal out through the upper thoracic spinal cord to the superior cervical ganglion of the sympathetic chain. The postganglionic fiber then projects to the iris, where it releases norepinephrine onto the radial fibers of the iris (a smooth muscle). When those fibers contract, the pupil dilates—increasing the amount of light hitting the retina. If light levels are too high, the parasympathetic system sends a signal out from the Edinger–Westphal nucleus through the oculomotor nerve. This fiber synapses in the ciliary ganglion in the posterior orbit. The postganglionic fiber then projects to the iris, where it releases ACh onto the circular fibers of the iris—another smooth muscle. When those fibers contract, the pupil constricts to limit the amount of light hitting the retina.

Autonomic Control of Pupillary Size



Activation of the pupillary reflex comes from the amount of light activating the retinal ganglion cells, as sent along the optic nerve. The output of the sympathetic system projects through the superior cervical ganglion, whereas the parasympathetic system originates out of the midbrain and projects through the oculomotor nerve to the ciliary ganglion, which then projects to the iris. The postganglionic fibers of either division release neurotransmitters onto the smooth muscles of the iris to cause changes in the pupillary size. Norepinephrine results in dilation and ACh results in constriction.

In this example, the autonomic system is controlling how much light hits the retina. It is a homeostatic reflex mechanism that keeps the activation of photoreceptors within certain limits. In the context of avoiding a threat like the lioness on the savannah, the sympathetic response for fight or flight will increase pupillary diameter so that more light hits the retina and more visual information is available for running away. Likewise, the parasympathetic response of rest reduces the amount of light reaching the retina, allowing the photoreceptors to cycle through bleaching and be regenerated for further visual perception; this is what the homeostatic process is attempting to maintain.

Note:



Watch this [video](#) to learn about the pupillary reflexes. The pupillary light reflex involves sensory input through the optic nerve and motor response through the oculomotor nerve to the ciliary ganglion, which projects to the circular fibers of the iris. As shown in this short animation, pupils will constrict to limit the amount of light falling on the retina under bright lighting conditions. What constitutes the afferent and efferent branches of the competing reflex (dilation)?

Autonomic Tone

Organ systems are balanced between the input from the sympathetic and parasympathetic divisions. When something upsets that balance, the

homeostatic mechanisms strive to return it to its regular state. For each organ system, there may be more of a sympathetic or parasympathetic tendency to the resting state, which is known as the **autonomic tone** of the system. For example, the heart rate was described above. Because the resting heart rate is the result of the parasympathetic system slowing the heart down from its intrinsic rate of 100 bpm, the heart can be said to be in parasympathetic tone.

In a similar fashion, another aspect of the cardiovascular system is primarily under sympathetic control. Blood pressure is partially determined by the contraction of smooth muscle in the walls of blood vessels. These tissues have adrenergic receptors that respond to the release of norepinephrine from postganglionic sympathetic fibers by constricting and increasing blood pressure. The hormones released from the adrenal medulla—epinephrine and norepinephrine—will also bind to these receptors. Those hormones travel through the bloodstream where they can easily interact with the receptors in the vessel walls. The parasympathetic system has no significant input to the systemic blood vessels, so the sympathetic system determines their tone.

There are a limited number of blood vessels that respond to sympathetic input in a different fashion. Blood vessels in skeletal muscle, particularly those in the lower limbs, are more likely to dilate. It does not have an overall effect on blood pressure to alter the tone of the vessels, but rather allows for blood flow to increase for those skeletal muscles that will be active in the fight-or-flight response. The blood vessels that have a parasympathetic projection are limited to those in the erectile tissue of the reproductive organs. Acetylcholine released by these postganglionic parasympathetic fibers cause the vessels to dilate, leading to the engorgement of the erectile tissue.

Note:**Homeostatic Imbalances****Orthostatic Hypotension**

Have you ever stood up quickly and felt dizzy for a moment? This is because, for one reason or another, blood is not getting to your brain so it is

briefly deprived of oxygen. When you change position from sitting or lying down to standing, your cardiovascular system has to adjust for a new challenge, keeping blood pumping up into the head while gravity is pulling more and more blood down into the legs.

The reason for this is a sympathetic reflex that maintains the output of the heart in response to postural change. When a person stands up, proprioceptors indicate that the body is changing position. A signal goes to the CNS, which then sends a signal to the upper thoracic spinal cord neurons of the sympathetic division. The sympathetic system then causes the heart to beat faster and the blood vessels to constrict. Both changes will make it possible for the cardiovascular system to maintain the rate of blood delivery to the brain. Blood is being pumped superiorly through the internal branch of the carotid arteries into the brain, against the force of gravity. Gravity is not increasing while standing, but blood is more likely to flow down into the legs as they are extended for standing. This sympathetic reflex keeps the brain well oxygenated so that cognitive and other neural processes are not interrupted.

Sometimes this does not work properly. If the sympathetic system cannot increase cardiac output, then blood pressure into the brain will decrease, and a brief neurological loss can be felt. This can be brief, as a slight “wooziness” when standing up too quickly, or a loss of balance and neurological impairment for a period of time. The name for this is orthostatic hypotension, which means that blood pressure goes below the homeostatic set point when standing. It can be the result of standing up faster than the reflex can occur, which may be referred to as a benign “head rush,” or it may be the result of an underlying cause.

There are two basic reasons that orthostatic hypotension can occur. First, blood volume is too low and the sympathetic reflex is not effective. This hypovolemia may be the result of dehydration or medications that affect fluid balance, such as diuretics or vasodilators. Both of these medications are meant to lower blood pressure, which may be necessary in the case of systemic hypertension, and regulation of the medications may alleviate the problem. Sometimes increasing fluid intake or water retention through salt intake can improve the situation.

The second underlying cause of orthostatic hypotension is autonomic failure. There are several disorders that result in compromised sympathetic functions. The disorders range from diabetes to multiple system atrophy (a

loss of control over many systems in the body), and addressing the underlying condition can improve the hypotension. For example, with diabetes, peripheral nerve damage can occur, which would affect the postganglionic sympathetic fibers. Getting blood glucose levels under control can improve neurological deficits associated with diabetes.

Chapter Review

Autonomic nervous system function is based on the visceral reflex. This reflex is similar to the somatic reflex, but the efferent branch is composed of two neurons. The central neuron projects from the spinal cord or brain stem to synapse on the ganglionic neuron that projects to the effector. The afferent branch of the somatic and visceral reflexes is very similar, as many somatic and special senses activate autonomic responses. However, there are visceral senses that do not form part of conscious perception. If a visceral sensation, such as cardiac pain, is strong enough, it will rise to the level of consciousness. However, the sensory homunculus does not provide a representation of the internal structures to the same degree as the surface of the body, so visceral sensations are often experienced as referred pain, such as feelings of pain in the left shoulder and arm in connection with a heart attack.

The role of visceral reflexes is to maintain a balance of function in the organ systems of the body. The two divisions of the autonomic system each play a role in effecting change, usually in competing directions. The sympathetic system increases heart rate, whereas the parasympathetic system decreases heart rate. The sympathetic system dilates the pupil of the eye, whereas the parasympathetic system constricts the pupil. The competing inputs can contribute to the resting tone of the organ system. Heart rate is normally under parasympathetic tone, whereas blood pressure is normally under sympathetic tone. The heart rate is slowed by the autonomic system at rest, whereas blood vessels retain a slight constriction at rest.

In a few systems of the body, the competing input from the two divisions is not the norm. The sympathetic tone of blood vessels is caused by the lack of

parasympathetic input to the systemic circulatory system. Only certain regions receive parasympathetic input that relaxes the smooth muscle wall of the blood vessels. Sweat glands are another example, which only receive input from the sympathetic system.

Interactive Link Questions

Exercise:

Problem:

Read this [article](#) to learn about a teenager who experiences a series of spells that suggest a stroke. He undergoes endless tests and seeks input from multiple doctors. In the end, one expert, one question, and a simple blood pressure cuff answers the question. Why would the heart have to beat faster when the teenager changes his body position from lying down to sitting, and then to standing?

Solution:

The effect of gravity on circulation means that it is harder to get blood up from the legs as the body takes on a vertical orientation.

Exercise:

Problem:

Watch this [video](#) to learn about the pupillary reflexes. The pupillary light reflex involves sensory input through the optic nerve and motor response through the oculomotor nerve to the ciliary ganglion, which projects to the circular fibers of the iris. As shown in this short animation, pupils will constrict to limit the amount of light falling on the retina under bright lighting conditions. What constitutes the afferent and efferent branches of the competing reflex (dilation)?

Solution:

The optic nerve still carries the afferent input, but the output is from the thoracic spinal cord, through the superior cervical ganglion, to the

radial fibers of the iris.

Review Questions

Exercise:

Problem:

Which of the following represents a sensory input that is *not* part of both the somatic and autonomic systems?

- a. vision
- b. taste
- c. baroreception
- d. proprioception

Solution:

C

Exercise:

Problem:

What is the term for a reflex that does *not* include a CNS component?

- a. long reflex
- b. visceral reflex
- c. somatic reflex
- d. short reflex

Solution:

D

Exercise:

Problem:

What neurotransmitter will result in constriction of the pupil?

- a. norepinephrine
- b. acetylcholine
- c. epinephrine
- d. serotonin

Solution:

B

Exercise:

Problem:

What gland produces a secretion that causes fight-or-flight responses in effectors?

- a. adrenal medulla
- b. salivatory gland
- c. reproductive gland
- d. thymus

Solution:

A

Exercise:

Problem: Which of the following is an incorrect pairing?

- a. norepinephrine dilates the pupil
- b. epinephrine increases blood pressure
- c. acetylcholine decreases digestion
- d. norepinephrine increases heart rate

Solution:

C

Critical Thinking Questions

Exercise:**Problem:**

Damage to internal organs will present as pain associated with a particular surface area of the body. Why would something like irritation to the diaphragm, which is between the thoracic and abdominal cavities, feel like pain in the shoulder or neck?

Solution:

The nerves that carry sensory information from the diaphragm enter the spinal cord in the cervical region where somatic sensory fibers from the shoulder and neck would enter. The brain superimposes this experience onto the sensory homunculus where the somatic nerves are connected.

Exercise:**Problem:**

Medical practice is paying more attention to the autonomic system in considering disease states. Why would autonomic tone be important in considering cardiovascular disease?

Solution:

Within the cardiovascular system, different aspects demonstrate variation in autonomic tone. Heart rate is under parasympathetic tone, and blood pressure is under sympathetic tone. Pharmaceuticals that treat cardiovascular disorders may be more effective if they work with

the normal state of the autonomic system. Alternatively, some disorders may be exacerbated by autonomic deficits and common therapies might not be as effective.

Glossary

autonomic tone

tendency of an organ system to be governed by one division of the autonomic nervous system over the other, such as heart rate being lowered by parasympathetic input at rest

afferent branch

component of a reflex arc that represents the input from a sensory neuron, for either a special or general sense

baroreceptor

mechanoreceptor that senses the stretch of blood vessels to indicate changes in blood pressure

efferent branch

component of a reflex arc that represents the output, with the target being an effector, such as muscle or glandular tissue

long reflex

reflex arc that includes the central nervous system

referred pain

the conscious perception of visceral sensation projected to a different region of the body, such as the left shoulder and arm pain as a sign for a heart attack

reflex arc

circuit of a reflex that involves a sensory input and motor output, or an afferent branch and an efferent branch, and an integrating center to connect the two branches

short reflex

reflex arc that does not include any components of the central nervous system

somatic reflex

reflex involving skeletal muscle as the effector, under the control of the somatic nervous system

visceral reflex

reflex involving an internal organ as the effector, under the control of the autonomic nervous system

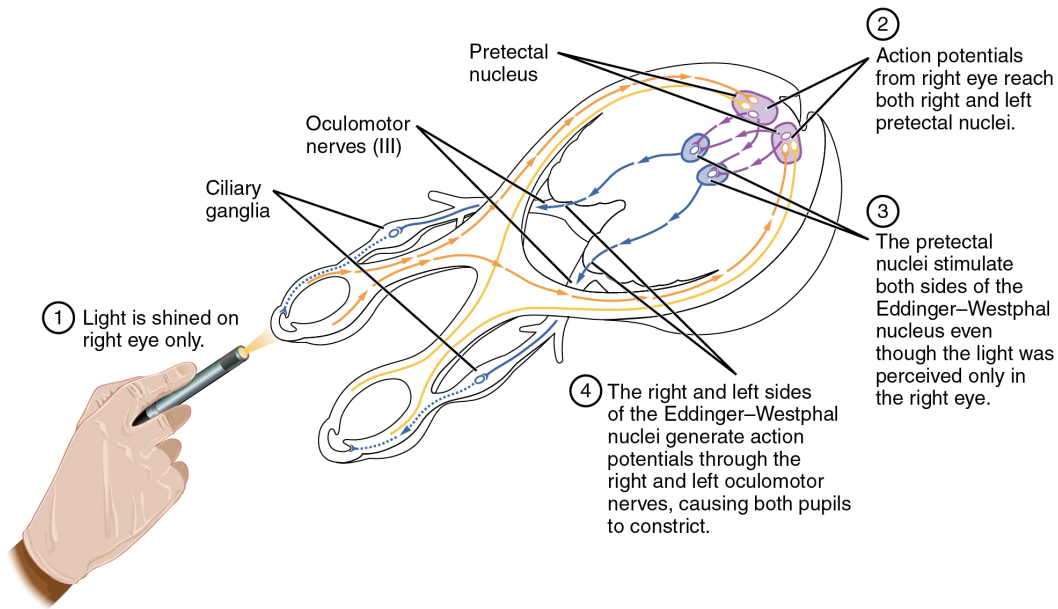
Central Control

By the end of this section, you will be able to:

- Describe the role of higher centers of the brain in autonomic regulation
- Explain the connection of the hypothalamus to homeostasis
- Describe the regions of the CNS that link the autonomic system with emotion
- Describe the pathways important to descending control of the autonomic system

The pupillary light reflex ([\[link\]](#)) begins when light hits the retina and causes a signal to travel along the optic nerve. This is visual sensation, because the afferent branch of this reflex is simply sharing the special sense pathway. Bright light hitting the retina leads to the parasympathetic response, through the oculomotor nerve, followed by the postganglionic fiber from the ciliary ganglion, which stimulates the circular fibers of the iris to contract and constrict the pupil. When light hits the retina in one eye, both pupils contract. When that light is removed, both pupils dilate again back to the resting position. When the stimulus is unilateral (presented to only one eye), the response is bilateral (both eyes). The same is not true for somatic reflexes. If you touch a hot radiator, you only pull that arm back, not both. Central control of autonomic reflexes is different than for somatic reflexes. The hypothalamus, along with other CNS locations, controls the autonomic system.

Pupillary Reflex Pathways



The pupil is under competing autonomic control in response to light levels hitting the retina. The sympathetic system will dilate the pupil when the retina is not receiving enough light, and the parasympathetic system will constrict the pupil when too much light hits the retina.

Forebrain Structures

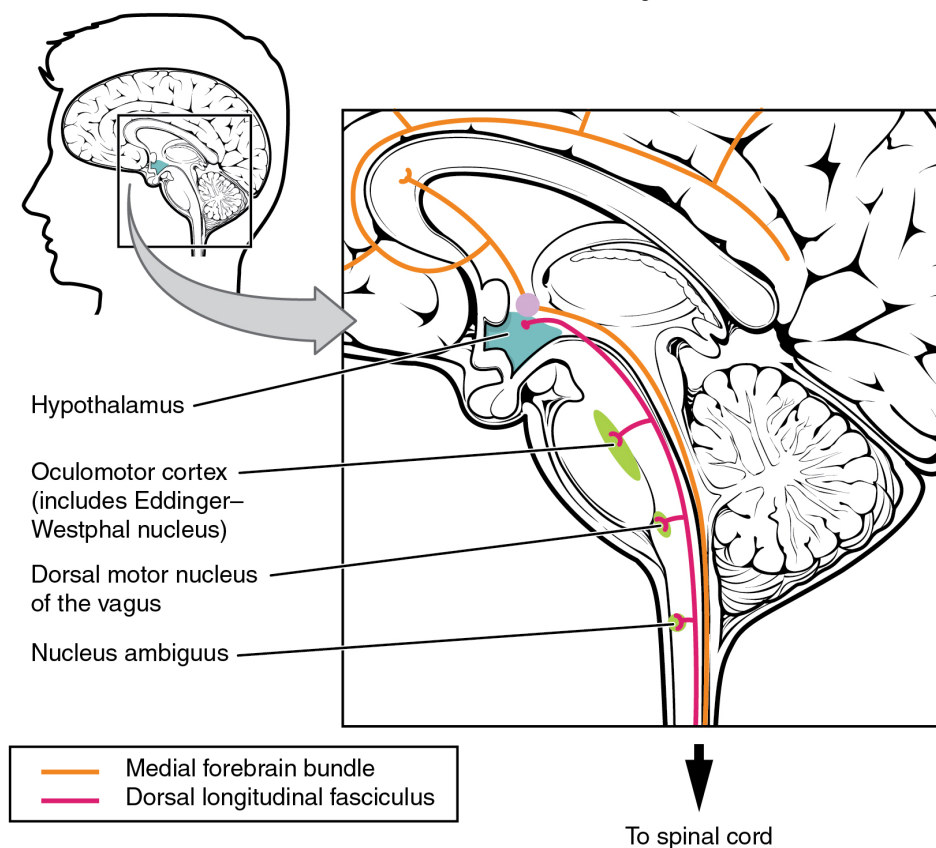
Autonomic control is based on the visceral reflexes, composed of the afferent and efferent branches. These homeostatic mechanisms are based on the balance between the two divisions of the autonomic system, which results in tone for various organs that is based on the predominant input from the sympathetic or parasympathetic systems. Coordinating that balance requires integration that begins with forebrain structures like the hypothalamus and continues into the brain stem and spinal cord.

The Hypothalamus

The hypothalamus is the control center for many homeostatic mechanisms. It regulates both autonomic function and endocrine function. The roles it plays in the pupillary reflexes demonstrates the importance of this control center. The optic nerve projects primarily to the thalamus, which is the necessary relay to the occipital cortex for conscious visual perception. Another projection of the optic nerve, however, goes to the hypothalamus.

The hypothalamus then uses this visual system input to drive the pupillary reflexes. If the retina is activated by high levels of light, the hypothalamus stimulates the parasympathetic response. If the optic nerve message shows that low levels of light are falling on the retina, the hypothalamus activates the sympathetic response. Output from the hypothalamus follows two main tracts, the **dorsal longitudinal fasciculus** and the **medial forebrain bundle** ([\[link\]](#)). Along these two tracts, the hypothalamus can influence the Edinger–Westphal nucleus of the oculomotor complex or the lateral horns of the thoracic spinal cord.

Fiber Tracts of the Central Autonomic System



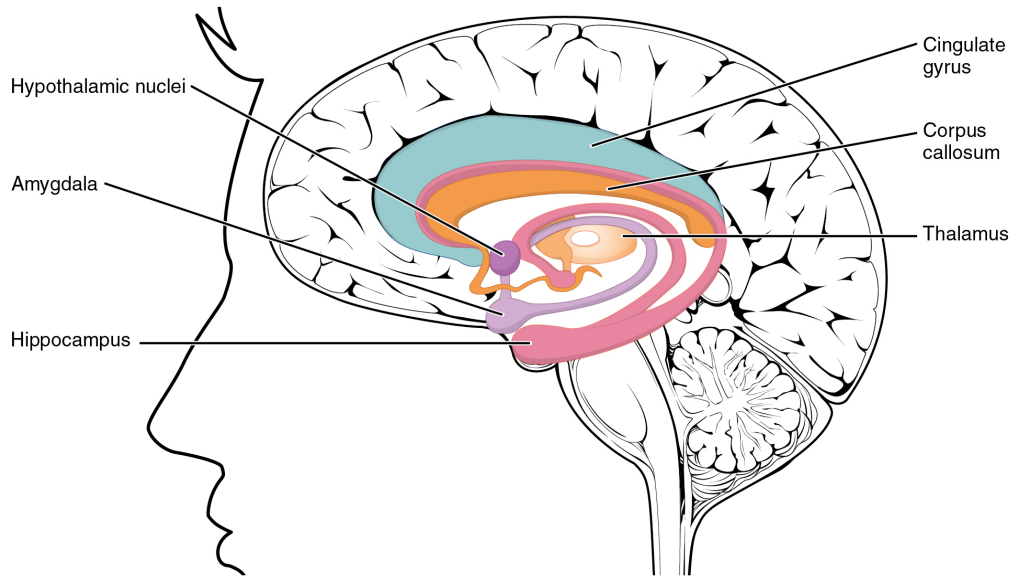
The hypothalamus is the source of most of the central control of autonomic function. It receives input from cerebral structures and projects to brain stem and spinal cord structures to regulate the balance of sympathetic and parasympathetic input to the organ systems of the body. The main pathways for this are the medial forebrain bundle and the dorsal longitudinal fasciculus.

These two tracts connect the hypothalamus with the major parasympathetic nuclei in the brain stem and the preganglionic (central) neurons of the thoracolumbar spinal cord. The hypothalamus also receives input from other areas of the forebrain through the medial forebrain bundle. The olfactory cortex, the septal nuclei of the basal forebrain, and the amygdala project into the hypothalamus through the medial forebrain bundle. These forebrain structures inform the hypothalamus about the state of the nervous system and can influence the regulatory processes of homeostasis. A good example of this is found in the amygdala, which is found beneath the cerebral cortex of the temporal lobe and plays a role in our ability to remember and feel emotions.

The Amygdala

The amygdala is a group of nuclei in the medial region of the temporal lobe that is part of the **limbic lobe** ([\[link\]](#)). The limbic lobe includes structures that are involved in emotional responses, as well as structures that contribute to memory function. The limbic lobe has strong connections with the hypothalamus and influences the state of its activity on the basis of emotional state. For example, when you are anxious or scared, the amygdala will send signals to the hypothalamus along the medial forebrain bundle that will stimulate the sympathetic fight-or-flight response. The hypothalamus will also stimulate the release of stress hormones through its control of the endocrine system in response to amygdala input.

The Limbic Lobe



Structures arranged around the edge of the cerebrum constitute the limbic lobe, which includes the amygdala, hippocampus, and cingulate gyrus, and connects to the hypothalamus.

The Medulla

The medulla contains nuclei referred to as the **cardiovascular center**, which controls the smooth and cardiac muscle of the cardiovascular system through autonomic connections. When the homeostasis of the cardiovascular system shifts, such as when blood pressure changes, the coordination of the autonomic system can be accomplished within this region. Furthermore, when descending inputs from the hypothalamus stimulate this area, the sympathetic system can increase activity in the cardiovascular system, such as in response to anxiety or stress. The preganglionic sympathetic fibers that are responsible for increasing heart rate are referred to as the **cardiac accelerator nerves**, whereas the preganglionic sympathetic fibers responsible for constricting blood vessels compose the **vasomotor nerves**.

Several brain stem nuclei are important for the visceral control of major organ systems. One brain stem nucleus involved in cardiovascular function is the solitary nucleus. It receives sensory input about blood pressure and cardiac function from the glossopharyngeal and vagus nerves, and its output will activate sympathetic stimulation of the heart or blood vessels through the upper thoracic lateral horn. Another brain stem nucleus important for visceral control is the dorsal motor nucleus of the vagus nerve, which is the motor nucleus for the parasympathetic functions ascribed to the vagus nerve, including decreasing the heart rate, relaxing bronchial tubes in the lungs, and activating digestive function through the enteric nervous system. The nucleus ambiguus, which is named for its ambiguous histology, also contributes to the parasympathetic output of the vagus nerve and targets muscles in the pharynx and larynx for swallowing and speech, as well as contributing to the parasympathetic tone of the heart along with the dorsal motor nucleus of the vagus.

Note:**Everyday Connections****Exercise and the Autonomic System**

In addition to its association with the fight-or-flight response and rest-and-digest functions, the autonomic system is responsible for certain everyday functions. For example, it comes into play when homeostatic mechanisms dynamically change, such as the physiological changes that accompany exercise. Getting on the treadmill and putting in a good workout will cause the heart rate to increase, breathing to be stronger and deeper, sweat glands to activate, and the digestive system to suspend activity. These are the same physiological changes associated with the fight-or-flight response, but there is nothing chasing you on that treadmill.

This is not a simple homeostatic mechanism at work because “maintaining the internal environment” would mean getting all those changes back to their set points. Instead, the sympathetic system has become active during exercise so that your body can cope with what is happening. A homeostatic mechanism is dealing with the conscious decision to push the body away from a resting state. The heart, actually, is moving away from its homeostatic set point. Without any input from the autonomic system, the

heart would beat at approximately 100 bpm, and the parasympathetic system slows that down to the resting rate of approximately 70 bpm. But in the middle of a good workout, you should see your heart rate at 120–140 bpm. You could say that the body is stressed because of what you are doing to it. Homeostatic mechanisms are trying to keep blood pH in the normal range, or to keep body temperature under control, but those are in response to the choice to exercise.

Note:



Watch this [video](#) to learn about physical responses to emotion. The autonomic system, which is important for regulating the homeostasis of the organ systems, is also responsible for our physiological responses to emotions such as fear. The video summarizes the extent of the body's reactions and describes several effects of the autonomic system in response to fear. On the basis of what you have already studied about autonomic function, which effect would you expect to be associated with parasympathetic, rather than sympathetic, activity?

Chapter Review

The autonomic system integrates sensory information and higher cognitive processes to generate output, which balances homeostatic mechanisms. The central autonomic structure is the hypothalamus, which coordinates sympathetic and parasympathetic efferent pathways to regulate activities of the organ systems of the body. The majority of hypothalamic output travels through the medial forebrain bundle and the dorsal longitudinal fasciculus

to influence brain stem and spinal components of the autonomic nervous system. The medial forebrain bundle also connects the hypothalamus with higher centers of the limbic system where emotion can influence visceral responses. The amygdala is a structure within the limbic system that influences the hypothalamus in the regulation of the autonomic system, as well as the endocrine system.

These higher centers have descending control of the autonomic system through brain stem centers, primarily in the medulla, such as the cardiovascular center. This collection of medullary nuclei regulates cardiac function, as well as blood pressure. Sensory input from the heart, aorta, and carotid sinuses project to these regions of the medulla. The solitary nucleus increases sympathetic tone of the cardiovascular system through the cardiac accelerator and vasomotor nerves. The nucleus ambiguus and the dorsal motor nucleus both contribute fibers to the vagus nerve, which exerts parasympathetic control of the heart by decreasing heart rate.

Interactive Link Questions

Exercise:

Problem:

Watch this [video](#) to learn about physical responses to emotion. The autonomic system, which is important for regulating the homeostasis of the organ systems, is also responsible for our physiological responses to emotions such as fear. The video summarizes the extent of the body's reactions and describes several effects of the autonomic system in response to fear. On the basis of what you have already studied about autonomic function, which effect would you expect to be associated with parasympathetic, rather than sympathetic, activity?

Solution:

The release of urine in extreme fear. The sympathetic system normally constricts sphincters such as that of the urethra.

Review Questions

Exercise:

Problem:

Which of these locations in the forebrain is the master control center for homeostasis through the autonomic and endocrine systems?

- a. hypothalamus
- b. thalamus
- c. amygdala
- d. cerebral cortex

Solution:

A

Exercise:

Problem:

Which nerve projects to the hypothalamus to indicate the level of light stimuli in the retina?

- a. glossopharyngeal
- b. oculomotor
- c. optic
- d. vagus

Solution:

C

Exercise:

Problem:

What region of the limbic lobe is responsible for generating stress responses via the hypothalamus?

- a. hippocampus
- b. amygdala
- c. mammillary bodies
- d. prefrontal cortex

Solution:

B

Exercise:**Problem:**

What is another name for the preganglionic sympathetic fibers that project to the heart?

- a. solitary tract
- b. vasomotor nerve
- c. vagus nerve
- d. cardiac accelerator nerve

Solution:

D

Exercise:**Problem:**

What central fiber tract connects forebrain and brain stem structures with the hypothalamus?

- a. cardiac accelerator nerve

- b. medial forebrain bundle
- c. dorsal longitudinal fasciculus
- d. corticospinal tract

Solution:

B

Critical Thinking Questions

Exercise:

Problem:

Horner's syndrome is a condition that presents with changes in one eye, such as pupillary constriction and dropping of eyelids, as well as decreased sweating in the face. Why could a tumor in the thoracic cavity have an effect on these autonomic functions?

Solution:

Pupillary dilation and sweating, two functions lost in Horner's syndrome, are caused by the sympathetic system. A tumor in the thoracic cavity may interrupt the output of the thoracic ganglia that project to the head and face.

Exercise:

Problem:

The cardiovascular center is responsible for regulating the heart and blood vessels through homeostatic mechanisms. What tone does each component of the cardiovascular system have? What connections does the cardiovascular center invoke to keep these two systems in their resting tone?

Solution:

The heart—based on the resting heart rate—is under parasympathetic tone, and the blood vessels—based on the lack of parasympathetic input—are under sympathetic tone. The vagus nerve contributes to the lowered resting heart rate, whereas the vasomotor nerves maintain the slight constriction of systemic blood vessels.

Glossary

cardiac accelerator nerves

preganglionic sympathetic fibers that cause the heart rate to increase when the cardiovascular center in the medulla initiates a signal

cardiovascular center

region in the medulla that controls the cardiovascular system through cardiac accelerator nerves and vasomotor nerves, which are components of the sympathetic division of the autonomic nervous system

dorsal longitudinal fasciculus

major output pathway of the hypothalamus that descends through the gray matter of the brain stem and into the spinal cord

limbic lobe

structures arranged around the edges of the cerebrum that are involved in memory and emotion

medial forebrain bundle

fiber pathway that extends anteriorly into the basal forebrain, passes through the hypothalamus, and extends into the brain stem and spinal cord

vasomotor nerves

preganglionic sympathetic fibers that cause the constriction of blood vessels in response to signals from the cardiovascular center

Drugs that Affect the Autonomic System

By the end of this section, you will be able to:

- List the classes of pharmaceuticals that interact with the autonomic nervous system
- Differentiate between cholinergic and adrenergic compounds
- Differentiate between sympathomimetic and sympatholytic drugs
- Relate the consequences of nicotine abuse with respect to autonomic control of the cardiovascular system

An important way to understand the effects of native neurochemicals in the autonomic system is in considering the effects of pharmaceutical drugs. This can be considered in terms of how drugs change autonomic function. These effects will primarily be based on how drugs act at the receptors of the autonomic system neurochemistry. The signaling molecules of the nervous system interact with proteins in the cell membranes of various target cells. In fact, no effect can be attributed to just the signaling molecules themselves without considering the receptors. A chemical that the body produces to interact with those receptors is called an **endogenous chemical**, whereas a chemical introduced to the system from outside is an **exogenous chemical**. Exogenous chemicals may be of a natural origin, such as a plant extract, or they may be synthetically produced in a pharmaceutical laboratory.

Broad Autonomic Effects

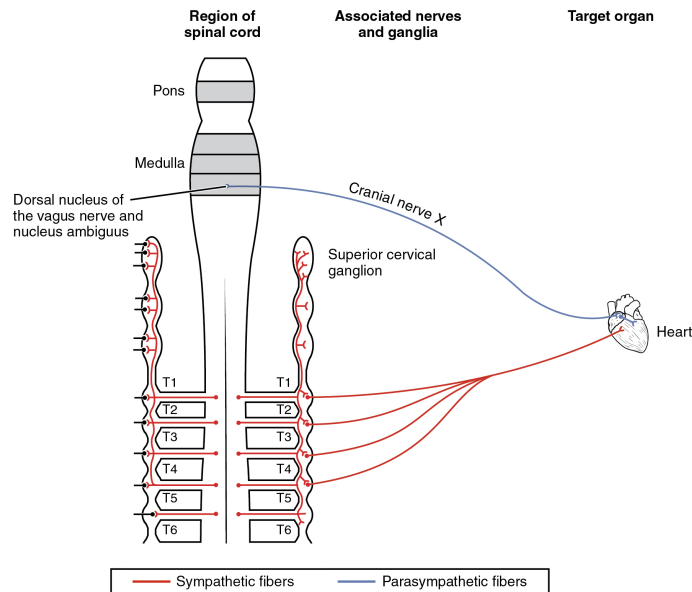
One important drug that affects the autonomic system broadly is not a pharmaceutical therapeutic agent associated with the system. This drug is nicotine. The effects of nicotine on the autonomic nervous system are important in considering the role smoking can play in health.

All ganglionic neurons of the autonomic system, in both sympathetic and parasympathetic ganglia, are activated by ACh released from preganglionic fibers. The ACh receptors on these neurons are of the nicotinic type, meaning that they are ligand-gated ion channels. When the neurotransmitter released from the preganglionic fiber binds to the receptor protein, a channel opens to allow positive ions to cross the cell membrane. The result is depolarization of the ganglia. Nicotine acts as an ACh analog at these synapses, so when someone takes in the drug, it binds to these ACh receptors and activates the ganglionic neurons, causing them to depolarize.

Ganglia of both divisions are activated equally by the drug. For many target organs in the body, this results in no net change. The competing inputs to the system cancel each other out and nothing significant happens. For example, the sympathetic system will cause sphincters in the digestive tract to contract, limiting digestive propulsion, but the parasympathetic system will cause the contraction of other muscles in the digestive tract, which will try to push the contents of the digestive system along. The end result is that the food does not really move along and the digestive system has not appreciably changed.

The system in which this can be problematic is in the cardiovascular system, which is why smoking is a risk factor for cardiovascular disease. First, there is no significant parasympathetic regulation of blood pressure. Only a limited number of blood vessels are affected by parasympathetic input, so nicotine will preferentially cause the vascular tone to become more sympathetic, which means blood pressure will be increased. Second, the autonomic control of the heart is special. Unlike skeletal or smooth muscles, cardiac muscle is intrinsically active, meaning that it generates its own action potentials. The autonomic system does not cause the heart to beat, it just speeds it up (sympathetic) or slows it down (parasympathetic). The mechanisms for this are not mutually exclusive, so the heart receives conflicting signals, and the rhythm of the heart can be affected ([link](#)).

Autonomic Connections to Heart and Blood Vessels



The nicotinic receptor is found on all autonomic ganglia, but the cardiovascular connections are particular, and do not conform to the usual competitive projections that would just cancel each other out when stimulated by nicotine. The opposing signals to the heart would both depolarize and hyperpolarize the heart cells that establish the rhythm of the heartbeat, likely causing arrhythmia. Only the sympathetic system governs systemic blood pressure so nicotine would cause an increase.

Sympathetic Effect

The neurochemistry of the sympathetic system is based on the adrenergic system. Norepinephrine and epinephrine influence target effectors by binding to the α -adrenergic or β -adrenergic receptors. Drugs that affect the sympathetic system affect these chemical systems. The drugs can be classified by whether they enhance the functions of the sympathetic system or interrupt those functions. A drug that enhances adrenergic function is known as a **sympathomimetic drug**, whereas a drug that interrupts adrenergic function is a **sympatholytic drug**.

Sympathomimetic Drugs

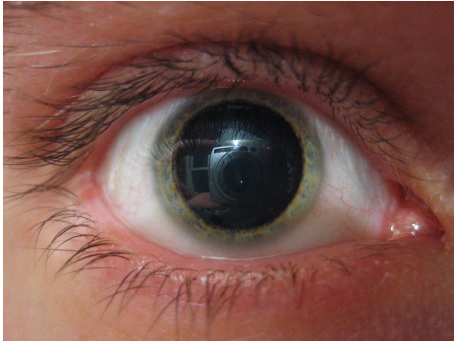
When the sympathetic system is not functioning correctly or the body is in a state of homeostatic imbalance, these drugs act at postganglionic terminals and synapses in the sympathetic efferent pathway. These drugs either bind to particular adrenergic receptors and mimic norepinephrine at the synapses between sympathetic postganglionic fibers and their targets, or they increase the production and release of norepinephrine from postganglionic fibers. Also, to increase the effectiveness of adrenergic chemicals released from the fibers, some of these drugs may block the removal or reuptake of the neurotransmitter from the synapse.

A common sympathomimetic drug is phenylephrine, which is a common component of decongestants. It can also be used to dilate the pupil and to raise blood pressure. Phenylephrine is known as an α_1 -adrenergic **agonist**, meaning that it binds to a specific adrenergic receptor, stimulating a response. In this role, phenylephrine will bind to the adrenergic receptors in bronchioles of the lungs and cause them to dilate. By opening these structures,

accumulated mucus can be cleared out of the lower respiratory tract. Phenylephrine is often paired with other pharmaceuticals, such as analgesics, as in the “sinus” version of many over-the-counter drugs, such as Tylenol Sinus[®] or Excedrin Sinus[®], or in expectorants for chest congestion such as in Robitussin CF[®].

A related molecule, called pseudoephedrine, was much more commonly used in these applications than was phenylephrine, until the molecule became useful in the illicit production of amphetamines. Phenylephrine is not as effective as a drug because it can be partially broken down in the digestive tract before it is ever absorbed. Like the adrenergic agents, phenylephrine is effective in dilating the pupil, known as **mydriasis** ([link](#)). Phenylephrine is used during an eye exam in an ophthalmologist’s or optometrist’s office for this purpose. It can also be used to increase blood pressure in situations in which cardiac function is compromised, such as under anesthesia or during septic shock.

Mydriasis



The sympathetic system causes pupillary dilation when norepinephrine binds to an adrenergic receptor in the radial fibers of the iris smooth muscle. Phenylephrine mimics this action by binding to the same receptor when drops are applied onto the surface of the eye in a doctor’s office. (credit: Corey Theiss)

Other drugs that enhance adrenergic function are not associated with therapeutic uses, but affect the functions of the sympathetic system in a similar fashion. Cocaine primarily interferes with the uptake of dopamine at the synapse and can also increase adrenergic function. Caffeine is an antagonist to a different neurotransmitter receptor, called the adenosine receptor. Adenosine will suppress adrenergic activity, specifically the release of norepinephrine at synapses, so caffeine indirectly increases adrenergic activity. There is some evidence that caffeine can aid in the therapeutic use of drugs, perhaps by potentiating (increasing) sympathetic function, as is suggested by the inclusion of caffeine in over-the-counter analgesics such as Excedrin[®].

Sympatholytic Drugs

Drugs that interfere with sympathetic function are referred to as sympatholytic, or sympathoplegic, drugs. They primarily work as an **antagonist** to the adrenergic receptors. They block the ability of norepinephrine or epinephrine to bind to the receptors so that the effect is “cut” or “takes a blow,” to refer to the endings “-lytic” and “-plegic,” respectively. The various drugs of this class will be specific to α -adrenergic or β -adrenergic receptors, or to their receptor subtypes.

Possibly the most familiar type of sympatholytic drug are the β -blockers. These drugs are often used to treat cardiovascular disease because they block the β -receptors associated with vasoconstriction and cardioacceleration.

By allowing blood vessels to dilate, or keeping heart rate from increasing, these drugs can improve cardiac function in a compromised system, such as for a person with congestive heart failure or who has previously suffered a heart attack. A couple of common versions of β -blockers are metoprolol, which specifically blocks the β_1 -receptor, and propranolol, which nonspecifically blocks β -receptors. There are other drugs that are α -blockers and can affect the sympathetic system in a similar way.

Other uses for sympatholytic drugs are as antianxiety medications. A common example of this is clonidine, which is an α -agonist. The sympathetic system is tied to anxiety to the point that the sympathetic response can be referred to as “fight, flight, or fright.” Clonidine is used for other treatments aside from hypertension and anxiety, including pain conditions and attention deficit hyperactivity disorder.

Parasympathetic Effects

Drugs affecting parasympathetic functions can be classified into those that increase or decrease activity at postganglionic terminals. Parasympathetic postganglionic fibers release ACh, and the receptors on the targets are muscarinic receptors. There are several types of muscarinic receptors, M1–M5, but the drugs are not usually specific to the specific types. Parasympathetic drugs can be either muscarinic agonists or antagonists, or have indirect effects on the cholinergic system. Drugs that enhance cholinergic effects are called **parasympathomimetic drugs**, whereas those that inhibit cholinergic effects are referred to as **anticholinergic drugs**.

Pilocarpine is a nonspecific muscarinic agonist commonly used to treat disorders of the eye. It reverses mydriasis, such as is caused by phenylephrine, and can be administered after an eye exam. Along with constricting the pupil through the smooth muscle of the iris, pilocarpine will also cause the ciliary muscle to contract. This will open perforations at the base of the cornea, allowing for the drainage of aqueous humor from the anterior compartment of the eye and, therefore, reducing intraocular pressure related to glaucoma.

Atropine and scopolamine are part of a class of muscarinic antagonists that come from the *Atropa* genus of plants that include belladonna or deadly nightshade ([link](#)). The name of one of these plants, belladonna, refers to the fact that extracts from this plant were used cosmetically for dilating the pupil. The active chemicals from this plant block the muscarinic receptors in the iris and allow the pupil to dilate, which is considered attractive because it makes the eyes appear larger. Humans are instinctively attracted to anything with larger eyes, which comes from the fact that the ratio of eye-to-head size is different in infants (or baby animals) and can elicit an emotional response. The cosmetic use of belladonna extract was essentially acting on this response. Atropine is no longer used in this cosmetic capacity for reasons related to the other name for the plant, which is deadly nightshade. Suppression of parasympathetic function, especially when it becomes systemic, can be fatal. Autonomic regulation is disrupted and anticholinergic symptoms develop. The berries of this plant are highly toxic, but can be mistaken for other berries. The antidote for atropine or scopolamine poisoning is pilocarpine.

Belladonna Plant



The plant from the genus *Atropa*, which is known as belladonna or deadly nightshade, was used cosmetically to dilate pupils, but can

be fatal when ingested. The berries on the plant may seem attractive as a fruit, but they contain the same anticholinergic compounds as the rest of the plant.

Sympathetic and Parasympathetic Effects of Different Drug Types				
Drug type	Example(s)	Sympathetic effect	Parasympathetic effect	Overall result
Nicotinic agonists	Nicotine	Mimic ACh at preganglionic synapses, causing activation of postganglionic fibers and the release of norepinephrine onto the target organ	Mimic ACh at preganglionic synapses, causing activation of postganglionic fibers and the release of ACh onto the target organ	Most conflicting signals cancel each other out but cardiovascular system is susceptible to hypertension and arrhythmia.
Sympathomimetic drugs	Phenylephrine	Bind to adrenergic receptors or mimics sympathetic action in some other way	No effect	Increase sympathetic tone
Sympatholytic drugs	β -blockers such as propranolol or metoprolol; α -agonists such as clonidine	Block binding to adrenergic drug or decrease adrenergic signals	No effect	Increase parasympathetic tone
Parasympathomimetics/muscarinic agonists	Pilocarpine	No effect, except on sweat glands	Bind to muscarinic receptor, similar to ACh	Increase parasympathetic tone
Anticholinergics/muscarinic antagonists	Atropine, scopolamine, dimenhydrinate	No effect	Block muscarinic receptors and parasympathetic function	Increase sympathetic tone

Note:**Disorders of the...****Autonomic Nervous System**

Approximately 33 percent of people experience a mild problem with motion sickness, whereas up to 66 percent experience motion sickness under extreme conditions, such as being on a tossing boat with no view of the horizon. Connections between regions in the brain stem and the autonomic system result in the symptoms of nausea, cold sweats, and vomiting.

The part of the brain responsible for vomiting, or emesis, is known as the area postrema. It is located next to the fourth ventricle and is not restricted by the blood–brain barrier, which allows it to respond to chemicals in the bloodstream—namely, toxins that will stimulate emesis. There are significant connections between this area, the solitary nucleus, and the dorsal motor nucleus of the vagus nerve. These autonomic system and nuclei connections are associated with the symptoms of motion sickness.

Motion sickness is the result of conflicting information from the visual and vestibular systems. If motion is perceived by the visual system without the complementary vestibular stimuli, or through vestibular stimuli without visual confirmation, the brain stimulates emesis and the associated symptoms. The area postrema, by itself, appears to be able to stimulate emesis in response to toxins in the blood, but it is also connected to the autonomic system and can trigger a similar response to motion.

Autonomic drugs are used to combat motion sickness. Though it is often described as a dangerous and deadly drug, scopolamine is used to treat motion sickness. A popular treatment for motion sickness is the transdermal scopolamine patch. Scopolamine is one of the substances derived from the *Atropa* genus along with atropine. At higher doses, those substances are thought to be poisonous and can lead to an extreme sympathetic syndrome. However, the transdermal patch regulates the release of the drug, and the concentration is kept very low so that the dangers are avoided. For those who are concerned about using “The Most Dangerous Drug,” as some websites will call it, antihistamines such as dimenhydrinate (Dramamine®) can be used.

Note:

Watch this [video](#) to learn about the side effects of 3-D movies. As discussed in this video, movies that are shot in 3-D can cause motion sickness, which elicits the autonomic symptoms of nausea and sweating. The disconnection between the perceived motion on the screen and the lack of any change in equilibrium stimulates these symptoms. Why do you think sitting close to the screen or right in the middle of the theater makes motion sickness during a 3-D movie worse?

Chapter Review

The autonomic system is affected by a number of exogenous agents, including some that are therapeutic and some that are illicit. These drugs affect the autonomic system by mimicking or interfering with the endogenous agents or their receptors. A survey of how different drugs affect autonomic function illustrates the role that the neurotransmitters and hormones play in autonomic function. Drugs can be thought of as chemical tools to effect changes in the system with some precision, based on where those drugs are effective.

Nicotine is not a drug that is used therapeutically, except for smoking cessation. When it is introduced into the body via products, it has broad effects on the autonomic system. Nicotine carries a risk for cardiovascular disease because of these broad effects. The drug stimulates both sympathetic and parasympathetic ganglia at the preganglionic fiber synapse. For most organ systems in the body, the competing input from the two postganglionic fibers will essentially cancel each other out. However, for the cardiovascular system, the results are different.

Because there is essentially no parasympathetic influence on blood pressure for the entire body, the sympathetic input is increased by nicotine, causing an increase in blood pressure. Also, the influence that the autonomic system has on the heart is not the same as for other systems. Other organs have smooth muscle or glandular tissue that is activated or inhibited by the autonomic system. Cardiac muscle is intrinsically active and is modulated by the autonomic system. The contradictory signals do not just cancel each other out, they alter the regularity of the heart rate and can cause arrhythmias. Both hypertension and arrhythmias are risk factors for heart disease.

Other drugs affect one division of the autonomic system or the other. The sympathetic system is affected by drugs that mimic the actions of adrenergic molecules (norepinephrine and epinephrine) and are called sympathomimetic drugs. Drugs such as phenylephrine bind to the adrenergic receptors and stimulate target organs just as sympathetic activity would. Other drugs are sympatholytic because they block adrenergic activity and cancel the sympathetic influence on the target organ. Drugs that act on the parasympathetic system also work by either enhancing the postganglionic signal or blocking it. A muscarinic agonist (or parasympathomimetic drug) acts just like ACh released by the parasympathetic postganglionic fiber. Anticholinergic drugs block muscarinic receptors, suppressing parasympathetic interaction with the organ.

Interactive Link Questions

Exercise:

Problem:

Watch this [video](#) to learn about the side effects of 3-D movies. As discussed in this video, movies that are shot in 3-D can cause motion sickness, which elicits the autonomic symptoms of nausea and sweating. The disconnection between the perceived motion on the screen and the lack of any change in equilibrium stimulates these symptoms. Why do you think sitting close to the screen or right in the middle of the theater makes motion sickness during a 3-D movie worse?

Solution:

When the visual field is completely taken up by the movie, the brain is confused by the lack of vestibular stimuli to match the visual stimuli. Sitting to the side, or so that the edges of the screen can be seen, will help by providing a stable visual cue along with the magic of the cinematic experience.

Review Questions

Exercise:

Problem:

A drug that affects both divisions of the autonomic system is going to bind to, or block, which type of neurotransmitter receptor?

- a. nicotinic
- b. muscarinic
- c. α -adrenergic
- d. β -adrenergic

Solution:

A

Exercise:

Problem: A drug is called an agonist if it _____.

- a. blocks a receptor
- b. interferes with neurotransmitter reuptake
- c. acts like the endogenous neurotransmitter by binding to its receptor
- d. blocks the voltage-gated calcium ion channel

Solution:

C

Exercise:

Problem: Which type of drug would be an antidote to atropine poisoning?

- a. nicotinic agonist
- b. anticholinergic
- c. muscarinic agonist
- d. α -blocker

Solution:

C

Exercise:

Problem: Which kind of drug would have anti-anxiety effects?

- a. nicotinic agonist
- b. anticholinergic
- c. muscarinic agonist
- d. α -blocker

Solution:

D

Exercise:

Problem: Which type of drug could be used to treat asthma by opening airways wider?

- a. sympatholytic drug
- b. sympathomimetic drug
- c. anticholinergic drug
- d. parasympathomimetic drug

Solution:

B

Critical Thinking Questions

Exercise:

Problem:

Why does smoking increase the risk of heart disease? Provide two reasons based on autonomic function.

Solution:

Blood vessels, and therefore blood pressure, are primarily influenced by only the sympathetic system. There is no parasympathetic influence on blood pressure, so nicotine activation of autonomic ganglia will preferentially increase blood pressure. Also, cardiac muscle tissue is only modulated by autonomic inputs, so the conflicting information from both sympathetic and parasympathetic postganglionic fibers will cause arrhythmias. Both hypertension and arrhythmias are cardiac risk factors.

Exercise:**Problem:**

Why might topical, cosmetic application of atropine or scopolamine from the belladonna plant not cause fatal poisoning, as would occur with ingestion of the plant?

Solution:

Drops of these substances into the eyes, as was once done cosmetically, blocks the muscarinic receptors in the smooth muscle of the iris. The concentration of this direct application is probably below the concentration that would cause poisoning if it got into the bloodstream. The possibility of that concentration being wrong and causing poisoning is too great, however, for atropine to be used as a cosmetic.

Glossary

agonist

any exogenous substance that binds to a receptor and produces a similar effect to the endogenous ligand

antagonist

any exogenous substance that binds to a receptor and produces an opposing effect to the endogenous ligand

anticholinergic drugs

drugs that interrupt or reduce the function of the parasympathetic system

endogenous chemical

substance produced and released within the body to interact with a receptor protein

exogenous chemical

substance from a source outside the body, whether it be another organism such as a plant or from the synthetic processes of a laboratory, that binds to a transmembrane receptor protein

mydriasis

dilation of the pupil; typically the result of disease, trauma, or drugs

parasympathomimetic drugs

drugs that enhance or mimic the function of the parasympathetic system

sympatholytic drug

drug that interrupts, or "lyses," the function of the sympathetic system

sympathomimetic drug

drug that enhances or mimics the function of the sympathetic system

Overview of the Neurological Exam

By the end of this section, you will be able to:

- List the major sections of the neurological exam
- Explain the connection between location and function in the nervous system
- Explain the benefit of a rapid assessment for neurological function in a clinical setting
- List the causes of neurological deficits
- Describe the different ischemic events in the nervous system

The **neurological exam** is a clinical assessment tool used to determine what specific parts of the CNS are affected by damage or disease. It can be performed in a short time—sometimes as quickly as 5 minutes—to establish neurological function. In the emergency department, this rapid assessment can make the difference with respect to proper treatment and the extent of recovery that is possible.

The exam is a series of subtests separated into five major sections. The first of these is the **mental status exam**, which assesses the higher cognitive functions such as memory, orientation, and language. Then there is the **cranial nerve exam**, which tests the function of the 12 cranial nerves and, therefore, the central and peripheral structures associated with them. The cranial nerve exam tests the sensory and motor functions of each of the nerves, as applicable. Two major sections, the **sensory exam** and the **motor exam**, test the sensory and motor functions associated with spinal nerves. Finally, the **coordination exam** tests the ability to perform complex and coordinated movements. The **gait exam**, which is often considered a sixth major exam, specifically assesses the motor function of walking and can be considered part of the coordination exam because walking is a coordinated movement.

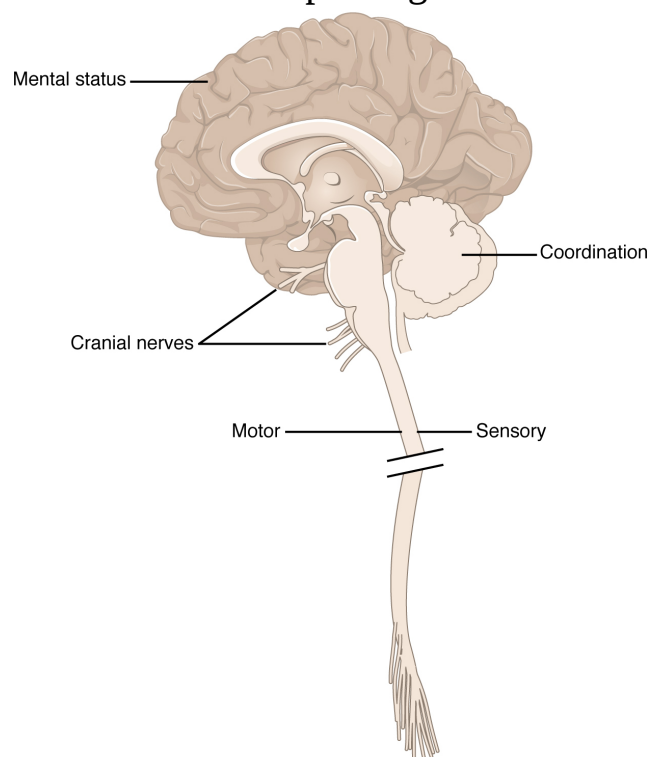
Neuroanatomy and the Neurological Exam

Localization of function is the concept that circumscribed locations are responsible for specific functions. The neurological exam highlights this relationship. For example, the cognitive functions that are assessed in the

mental status exam are based on functions in the cerebrum, mostly in the cerebral cortex. Several of the subtests examine language function. Deficits in neurological function uncovered by these examinations usually point to damage to the left cerebral cortex. In the majority of individuals, language function is localized to the left hemisphere between the superior temporal lobe and the posterior frontal lobe, including the intervening connections through the inferior parietal lobe.

The five major sections of the neurological exam are related to the major regions of the CNS ([link](#)). The mental status exam assesses functions related to the cerebrum. The cranial nerve exam is for the nerves that connect to the diencephalon and brain stem (as well as the olfactory connections to the forebrain). The coordination exam and the related gait exam primarily assess the functions of the cerebellum. The motor and sensory exams are associated with the spinal cord and its connections through the spinal nerves.

Anatomical Underpinnings of the Neurological Exam



The different regions of the CNS relate to the major sections of the neurological exam: the mental

status exam, cranial nerve exam, sensory exam, motor exam, and coordination exam (including the gait exam).

Part of the power of the neurological exam is this link between structure and function. Testing the various functions represented in the exam allows an accurate estimation of where the nervous system may be damaged. Consider the patient described in the chapter introduction. In the emergency department, he is given a quick exam to find where the deficit may be localized. Knowledge of where the damage occurred will lead to the most effective therapy.

In rapid succession, he is asked to smile, raise his eyebrows, stick out his tongue, and shrug his shoulders. The doctor tests muscular strength by providing resistance against his arms and legs while he tries to lift them. With his eyes closed, he has to indicate when he feels the tip of a pen touch his legs, arms, fingers, and face. He follows the tip of a pen as the doctor moves it through the visual field and finally toward his face. A formal mental status exam is not needed at this point; the patient will demonstrate any possible deficits in that area during normal interactions with the interviewer. If cognitive or language deficits are apparent, the interviewer can pursue mental status in more depth. All of this takes place in less than 5 minutes. The patient reports that he feels pins and needles in his left arm and leg, and has trouble feeling the tip of the pen when he is touched on those limbs. This suggests a problem with the sensory systems between the spinal cord and the brain. The emergency department has a lead to follow before a CT scan is performed. He is put on aspirin therapy to limit the possibility of blood clots forming, in case the cause is an **embolus**—an obstruction such as a blood clot that blocks the flow of blood in an artery or vein.

Note:



Watch this [video](#) to see a demonstration of the neurological exam—a series of tests that can be performed rapidly when a patient is initially brought into an emergency department. The exam can be repeated on a regular basis to keep a record of how and if neurological function changes over time. In what order were the sections of the neurological exam tested in this video, and which section seemed to be left out?

Causes of Neurological Deficits

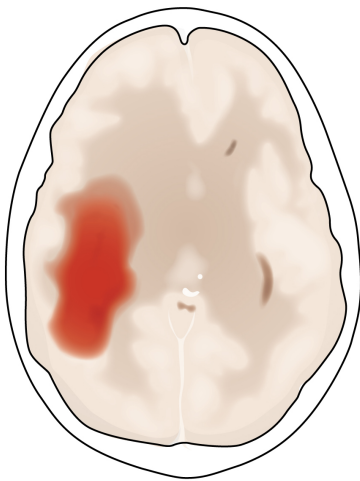
Damage to the nervous system can be limited to individual structures or can be distributed across broad areas of the brain and spinal cord. Localized, limited injury to the nervous system is most often the result of circulatory problems. Neurons are very sensitive to oxygen deprivation and will start to deteriorate within 1 or 2 minutes, and permanent damage (cell death) could result within a few hours. The loss of blood flow to part of the brain is known as a **stroke**, or a cerebrovascular accident (CVA).

There are two main types of stroke, depending on how the blood supply is compromised: ischemic and hemorrhagic. An **ischemic stroke** is the loss of blood flow to an area because vessels are blocked or narrowed. This is often caused by an embolus, which may be a blood clot or fat deposit. Ischemia may also be the result of thickening of the blood vessel wall, or a drop in blood volume in the brain known as **hypovolemia**.

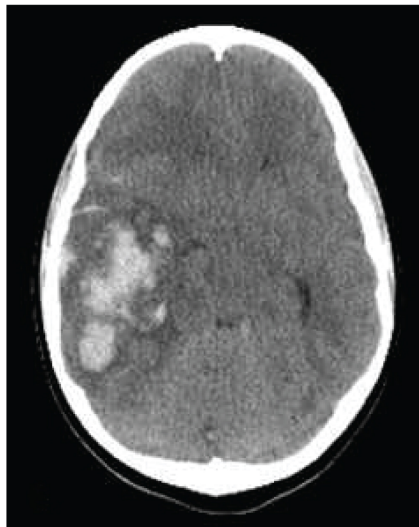
A related type of CVA is known as a **transient ischemic attack (TIA)**, which is similar to a stroke although it does not last as long. The diagnostic definition of a stroke includes effects that last at least 24 hours. Any stroke symptoms that are resolved within a 24-hour period because of restoration of adequate blood flow are classified as a TIA.

A **hemorrhagic stroke** is bleeding into the brain because of a damaged blood vessel. Accumulated blood fills a region of the cranial vault and presses against the tissue in the brain ([\[link\]](#)). Physical pressure on the brain can cause the loss of function, as well as the squeezing of local arteries resulting in compromised blood flow beyond the site of the hemorrhage. As blood pools in the nervous tissue and the vasculature is damaged, the blood-brain barrier can break down and allow additional fluid to accumulate in the region, which is known as **edema**.

Hemorrhagic Stroke



(a)



(b)

(a) A hemorrhage into the tissue of the cerebrum results in a large accumulation of blood with an additional edema in the adjacent tissue. The hemorrhagic area causes the entire brain to be disfigured as suggested here by the lateral ventricles being squeezed into the opposite hemisphere. (b) A CT scan shows an intraparenchymal hemorrhage within the parietal lobe. (credit b: James Heilman)

Whereas hemorrhagic stroke may involve bleeding into a large region of the CNS, such as into the deep white matter of a cerebral hemisphere, other events can cause widespread damage and loss of neurological functions.

Infectious diseases can lead to loss of function throughout the CNS as components of nervous tissue, specifically astrocytes and microglia, react to the disease. Blunt force trauma, such as from a motor vehicle accident, can physically damage the CNS.

A class of disorders that affect the nervous system are the neurodegenerative diseases: Alzheimer's disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis (ALS), Creutzfeldt–Jacob disease, multiple sclerosis (MS), and other disorders that are the result of nervous tissue degeneration. In diseases like Alzheimer's, Parkinson's, or ALS, neurons die; in diseases like MS, myelin is affected. Some of these disorders affect motor function, and others present with dementia. How patients with these disorders perform in the neurological exam varies, but is often broad in its effects, such as memory deficits that compromise many aspects of the mental status exam, or movement deficits that compromise aspects of the cranial nerve exam, the motor exam, or the coordination exam. The causes of these disorders are also varied. Some are the result of genetics, such as Huntington's disease, or the result of autoimmunity, such as MS; others are not entirely understood, such as Alzheimer's and Parkinson's diseases. Current research suggests that many of these diseases are related in how the degeneration takes place and may be treated by common therapies.

Finally, a common cause of neurological changes is observed in developmental disorders. Whether the result of genetic factors or the environment during development, there are certain situations that result in neurological functions being different from the expected norms. Developmental disorders are difficult to define because they are caused by defects that existed in the past and disrupted the normal development of the CNS. These defects probably involve multiple environmental and genetic factors—most of the time, we don't know what the cause is other than that it is more complex than just one factor. Furthermore, each defect on its own may not be a problem, but when several are added together, they can disrupt growth processes that are not well understood in the first place. For instance, it is possible for a stroke to damage a specific region of the brain and lead to the loss of the ability to recognize faces (prosopagnosia). The link between cell death in the fusiform gyrus and the symptom is relatively

easy to understand. In contrast, similar deficits can be seen in children with the developmental disorder, autism spectrum disorder (ASD). However, these children do not lack a fusiform gyrus, nor is there any damage or defect visible to this brain region. We conclude, rather poorly, that this brain region is not connected properly to other brain regions.

Infection, trauma, and congenital disorders can all lead to significant signs, as identified through the neurological exam. It is important to differentiate between an acute event, such as stroke, and a chronic or global condition such as blunt force trauma. Responses seen in the neurological exam can help. A loss of language function observed in all its aspects is more likely a global event as opposed to a discrete loss of one function, such as not being able to say certain types of words. A concern, however, is that a specific function—such as controlling the muscles of speech—may mask other language functions. The various subtests within the mental status exam can address these finer points and help clarify the underlying cause of the neurological loss.

Note:



Watch this [video](#) for an introduction to the neurological exam. Studying the neurological exam can give insight into how structure and function in the nervous system are interdependent. This is a tool both in the clinic and in the classroom, but for different reasons. In the clinic, this is a powerful but simple tool to assess a patient's neurological function. In the classroom, it is a different way to think about the nervous system. Though medical technology provides noninvasive imaging and real-time functional data, the presenter says these cannot replace the history at the core of the medical examination. What does history mean in the context of medical practice?

Chapter Review

The neurological exam is a clinical assessment tool to determine the extent of function from the nervous system. It is divided into five major sections that each deal with a specific region of the CNS. The mental status exam is concerned with the cerebrum and assesses higher functions such as memory, language, and emotion. The cranial nerve exam tests the functions of all of the cranial nerves and, therefore, their connections to the CNS through the forebrain and brain stem. The sensory and motor exams assess those functions as they relate to the spinal cord, as well as the combination of the functions in spinal reflexes. The coordination exam targets cerebellar function in coordinated movements, including those functions associated with gait.

Damage to and disease of the nervous system lead to loss of function. The location of the injury will correspond to the functional loss, as suggested by the principle of localization of function. The neurological exam provides the opportunity for a clinician to determine where damage has occurred on the basis of the function that is lost. Damage from acute injuries such as strokes may result in specific functions being lost, whereas broader effects in infection or developmental disorders may result in general losses across an entire section of the neurological exam.

Interactive Link Questions

Exercise:

Problem:

Watch this [video](#) that provides a demonstration of the neurological exam—a series of tests that can be performed rapidly when a patient is initially brought into an emergency department. The exam can be repeated on a regular basis to keep a record of how and if neurological function changes over time. In what order were the sections of the neurological exam tested in this video, and which section seemed to be left out?

Solution:

Coordination and gait were tested first, followed by mental status, motor, sensory, and reflexes. There were no specific tests of the cranial nerves.

Exercise:**Problem:**

Watch this [video](#) for an introduction to the neurological exam. Studying the neurological exam can give insight into how structure and function in the nervous system are interdependent. This is a tool both in the clinic and in the classroom, but for different reasons. In the clinic, this is a powerful but simple tool to assess a patient's neurological function. In the classroom, it is a different way to think about the nervous system. Though medical technology provides noninvasive imaging and real-time functional data, the presenter says these cannot replace the history at the core of the medical examination. What does history mean in the context of medical practice?

Solution:

History is the report from the patient, or others familiar with the patient, that can assist in diagnosis and formulation of treatment and care—essentially the result of an interview with the patient.

Review Questions

Exercise:

Problem:

Which major section of the neurological exam is *most likely* to reveal damage to the cerebellum?

- a. cranial nerve exam
- b. mental status exam
- c. sensory exam
- d. coordination exam

Solution:

D

Exercise:

Problem:

What function would *most likely* be affected by a restriction of a blood vessel in the cerebral cortex?

- a. language
- b. gait
- c. facial expressions
- d. knee-jerk reflex

Solution:

A

Exercise:

Problem:

Which major section of the neurological exam includes subtests that are sometimes considered a separate set of tests concerned with walking?

- a. mental status exam
- b. cranial nerve exam
- c. coordination exam
- d. sensory exam

Solution:

C

Exercise:**Problem:**

Memory, emotional, language, and sensorimotor deficits together are *most likely* the result of what kind of damage?

- a. stroke
- b. developmental disorder
- c. whiplash
- d. gunshot wound

Solution:

B

Exercise:**Problem:**

Where is language function localized in the majority of people?

- a. cerebellum

- b. right cerebral hemisphere
- c. hippocampus
- d. left cerebral hemisphere

Solution:

D

Critical Thinking Questions

Exercise:

Problem:

Why is a rapid assessment of neurological function important in an emergency situation?

Solution:

If an ischemic event has occurred, nervous tissue may be compromised, but quick intervention—possibly within a few hours—may be the critical aspect of recovery.

Exercise:

Problem:

How is the diagnostic category of TIA different from a stroke?

Solution:

The main difference between a stroke and TIA is time. If the result of a cerebrovascular accident lasts longer than 24 hours, then it is considered a stroke. Otherwise, it is considered transient and is labeled a TIA.

Glossary

coordination exam

major section of the neurological exam that assesses complex, coordinated motor functions of the cerebellum and associated motor pathways

cranial nerve exam

major section of the neurological exam that assesses sensory and motor functions of the cranial nerves and their associated central and peripheral structures

edema

fluid accumulation in tissue; often associated with circulatory deficits

embolus

obstruction in a blood vessel such as a blood clot, fatty mass, air bubble, or other foreign matter that interrupts the flow of blood to an organ or some part of the body

gait exam

major section of the neurological exam that assesses the cerebellum and descending pathways in the spinal cord through the coordinated motor functions of walking; a portion of the coordination exam

hemorrhagic stroke

disruption of blood flow to the brain caused by bleeding within the cranial vault

hypovolemia

decrease in blood volume

ischemic stroke

disruption of blood flow to the brain because blood cannot flow through blood vessels as a result of a blockage or narrowing of the vessel

localization of function

principle that circumscribed anatomical locations are responsible for specific functions in an organ system

mental status exam

major section of the neurological exam that assesses cognitive functions of the cerebrum

motor exam

major section of the neurological exam that assesses motor functions of the spinal cord and spinal nerves

neurological exam

clinical assessment tool that can be used to quickly evaluate neurological function and determine if specific parts of the nervous system have been affected by damage or disease

sensory exam

major section of the neurological exam that assesses sensory functions of the spinal cord and spinal nerves

stroke

(also, cerebrovascular accident (CVA)) loss of neurological function caused by an interruption of blood flow to a region of the central nervous system

transient ischemic attack (TIA)

temporary disruption of blood flow to the brain in which symptoms occur rapidly but last only a short time

The Mental Status Exam

By the end of this section, you will be able to:

- Describe the relationship of mental status exam results to cerebral functions
- Explain the categorization of regions of the cortex based on anatomy and physiology
- Differentiate between primary, association, and integration areas of the cerebral cortex
- Provide examples of localization of function related to the cerebral cortex

In the clinical setting, the set of subtests known as the mental status exam helps us understand the relationship of the brain to the body. Ultimately, this is accomplished by assessing behavior. Tremors related to intentional movements, incoordination, or the neglect of one side of the body can be indicative of failures of the connections of the cerebrum either within the hemispheres, or from the cerebrum to other portions of the nervous system. There is no strict test for what the cerebrum does alone, but rather in what it does through its control of the rest of the CNS, the peripheral nervous system (PNS), and the musculature.

Sometimes eliciting a behavior is as simple as asking a question. Asking a patient to state his or her name is not only to verify that the file folder in a health care provider's hands is the correct one, but also to be sure that the patient is aware, oriented, and capable of interacting with another person. If the answer to "What is your name?" is "Santa Claus," the person may have a problem understanding reality. If the person just stares at the examiner with a confused look on their face, the person may have a problem understanding or producing speech.

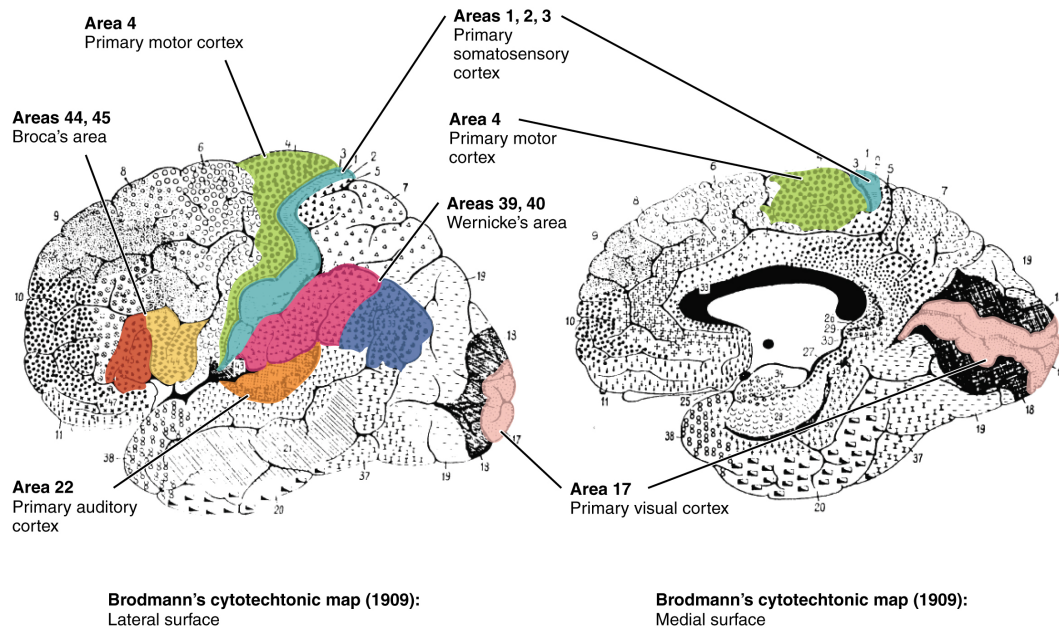
Functions of the Cerebral Cortex

The cerebrum is the seat of many of the higher mental functions, such as memory and learning, language, and conscious perception, which are the subjects of subtests of the mental status exam. The cerebral cortex is the thin layer of gray matter on the outside of the cerebrum. It is approximately

a millimeter thick in most regions and highly folded to fit within the limited space of the cranial vault. These higher functions are distributed across various regions of the cortex, and specific locations can be said to be responsible for particular functions. There is a limited set of regions, for example, that are involved in language function, and they can be subdivided on the basis of the particular part of language function that each governs.

The basis for parceling out areas of the cortex and attributing them to various functions has its root in pure anatomical underpinnings. The German neurologist and histologist Korbinian Brodmann, who made a careful study of the **cytoarchitecture** of the cerebrum around the turn of the nineteenth century, described approximately 50 regions of the cortex that differed enough from each other to be considered separate areas ([\[link\]](#)). Brodmann made preparations of many different regions of the cerebral cortex to view with a microscope. He compared the size, shape, and number of neurons to find anatomical differences in the various parts of the cerebral cortex. Continued investigation into these anatomical areas over the subsequent 100 or more years has demonstrated a strong correlation between the structures and the functions attributed to those structures. For example, the first three areas in Brodmann's list—which are in the postcentral gyrus—compose the primary somatosensory cortex. Within this area, finer separation can be made on the basis of the concept of the sensory homunculus, as well as the different submodalities of somatosensation such as touch, vibration, pain, temperature, or proprioception. Today, we more frequently refer to these regions by their function (i.e., primary sensory cortex) than by the number Brodmann assigned to them, but in some situations the use of Brodmann numbers persists.

Brodmann's Areas of the Cerebral Cortex



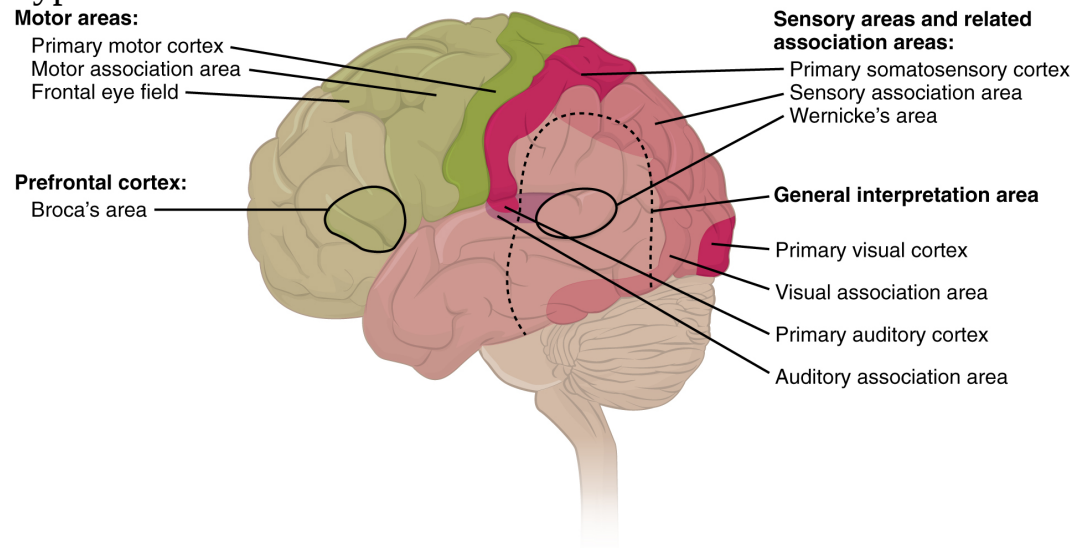
On the basis of cytoarchitecture, the anatomist Korbinian Brodmann described the extensive array of cortical regions, as illustrated in his figure. Subsequent investigations found that these areas corresponded very well to functional differences in the cerebral cortex. (credit: modification of work by “Looie496”/Wikimedia Commons, based on original work by Korvinian Brodmann)

Area 17, as Brodmann described it, is also known as the primary visual cortex. Adjacent to that are areas 18 and 19, which constitute subsequent regions of visual processing. Area 22 is the primary auditory cortex, and it is followed by area 23, which further processes auditory information. Area 4 is the primary motor cortex in the precentral gyrus, whereas area 6 is the premotor cortex. These areas suggest some specialization within the cortex for functional processing, both in sensory and motor regions. The fact that Brodmann's areas correlate so closely to functional localization in the cerebral cortex demonstrates the strong link between structure and function in these regions.

Areas 1, 2, 3, 4, 17, and 22 are each described as primary cortical areas. The adjoining regions are each referred to as association areas. Primary areas

are where sensory information is initially received from the thalamus for conscious perception, or—in the case of the primary motor cortex—where descending commands are sent down to the brain stem or spinal cord to execute movements ([\[link\]](#)).

Types of Cortical Areas



The cerebral cortex can be described as containing three types of processing regions: primary, association, and integration areas. The primary cortical areas are where sensory information is initially processed, or where motor commands emerge to go to the brain stem or spinal cord. Association areas are adjacent to primary areas and further process the modality-specific input. Multimodal integration areas are found where the modality-specific regions meet; they can process multiple modalities together or different modalities on the basis of similar functions, such as spatial processing in vision or somatosensation.

A number of other regions, which extend beyond these primary or association areas of the cortex, are referred to as integrative areas. These areas are found in the spaces between the domains for particular sensory or motor functions, and they integrate multisensory information, or process sensory or motor information in more complex ways. Consider, for

example, the posterior parietal cortex that lies between the somatosensory cortex and visual cortex regions. This has been ascribed to the coordination of visual and motor functions, such as reaching to pick up a glass. The somatosensory function that would be part of this is the proprioceptive feedback from moving the arm and hand. The weight of the glass, based on what it contains, will influence how those movements are executed.

Cognitive Abilities

Assessment of cerebral functions is directed at cognitive abilities. The abilities assessed through the mental status exam can be separated into four groups: orientation and memory, language and speech, sensorium, and judgment and abstract reasoning.

Orientation and Memory

Orientation is the patient's awareness of his or her immediate circumstances. It is awareness of time, not in terms of the clock, but of the date and what is occurring around the patient. It is awareness of place, such that a patient should know where he or she is and why. It is also awareness of who the patient is—recognizing personal identity and being able to relate that to the examiner. The initial tests of orientation are based on the questions, “Do you know what the date is?” or “Do you know where you are?” or “What is your name?” Further understanding of a patient's awareness of orientation can come from questions that address remote memory, such as “Who is the President of the United States?”, or asking what happened on a specific date.

There are also specific tasks to address memory. One is the three-word recall test. The patient is given three words to recall, such as book, clock, and shovel. After a short interval, during which other parts of the interview continue, the patient is asked to recall the three words. Other tasks that assess memory—aside from those related to orientation—have the patient recite the months of the year in reverse order to avoid the overlearned

sequence and focus on the memory of the months in an order, or to spell common words backwards, or to recite a list of numbers back.

Memory is largely a function of the temporal lobe, along with structures beneath the cerebral cortex such as the hippocampus and the amygdala. The storage of memory requires these structures of the medial temporal lobe. A famous case of a man who had both medial temporal lobes removed to treat intractable epilepsy provided insight into the relationship between the structures of the brain and the function of memory.

Henry Molaison, who was referred to as patient HM when he was alive, had epilepsy localized to both of his medial temporal lobes. In 1953, a bilateral lobectomy was performed that alleviated the epilepsy but resulted in the inability for HM to form new memories—a condition called **anterograde amnesia**. HM was able to recall most events from before his surgery, although there was a partial loss of earlier memories, which is referred to as **retrograde amnesia**. HM became the subject of extensive studies into how memory works. What he was unable to do was form new memories of what happened to him, what are now called **episodic memory**. Episodic memory is autobiographical in nature, such as remembering riding a bicycle as a child around the neighborhood, as opposed to the **procedural memory** of how to ride a bike. HM also retained his **short-term memory**, such as what is tested by the three-word task described above. After a brief period, those memories would dissipate or decay and not be stored in the long-term because the medial temporal lobe structures were removed.

The difference in short-term, procedural, and episodic memory, as evidenced by patient HM, suggests that there are different parts of the brain responsible for those functions. The long-term storage of episodic memory requires the hippocampus and related medial temporal structures, and the location of those memories is in the multimodal integration areas of the cerebral cortex. However, short-term memory—also called working or active memory—is localized to the prefrontal lobe. Because patient HM had only lost his medial temporal lobe—and lost very little of his previous memories, and did not lose the ability to form new short-term memories—it was concluded that the function of the hippocampus, and adjacent structures in the medial temporal lobe, is to move (or consolidate) short-term

memories (in the pre-frontal lobe) to long-term memory (in the temporal lobe).

The prefrontal cortex can also be tested for the ability to organize information. In one subtest of the mental status exam called set generation, the patient is asked to generate a list of words that all start with the same letter, but not to include proper nouns or names. The expectation is that a person can generate such a list of at least 10 words within 1 minute. Many people can likely do this much more quickly, but the standard separates the accepted normal from those with compromised prefrontal cortices.

Note:



Read this [article](#) to learn about a young man who texts his fiancée in a panic as he finds that he is having trouble remembering things. At the hospital, a neurologist administers the mental status exam, which is mostly normal except for the three-word recall test. The young man could not recall them even 30 seconds after hearing them and repeating them back to the doctor. An undiscovered mass in the mediastinum region was found to be Hodgkin's lymphoma, a type of cancer that affects the immune system and likely caused antibodies to attack the nervous system. The patient eventually regained his ability to remember, though the events in the hospital were always elusive. Considering that the effects on memory were temporary, but resulted in the loss of the specific events of the hospital stay, what regions of the brain were likely to have been affected by the antibodies and what type of memory does that represent?

Language and Speech

Language is, arguably, a very human aspect of neurological function. There are certainly strides being made in understanding communication in other species, but much of what makes the human experience seemingly unique is its basis in language. Any understanding of our species is necessarily reflective, as suggested by the question “What am I?” And the fundamental answer to this question is suggested by the famous quote by René Descartes: “Cogito Ergo Sum” (translated from Latin as “I think, therefore I am”). Formulating an understanding of yourself is largely describing who you are to yourself. It is a confusing topic to delve into, but language is certainly at the core of what it means to be self-aware.

The neurological exam has two specific subtests that address language. One measures the ability of the patient to understand language by asking them to follow a set of instructions to perform an action, such as “touch your right finger to your left elbow and then to your right knee.” Another subtest assesses the fluency and coherency of language by having the patient generate descriptions of objects or scenes depicted in drawings, and by reciting sentences or explaining a written passage. Language, however, is important in so many ways in the neurological exam. The patient needs to know what to do, whether it is as simple as explaining how the knee-jerk reflex is going to be performed, or asking a question such as “What is your name?” Often, language deficits can be determined without specific subtests; if a person cannot reply to a question properly, there may be a problem with the reception of language.

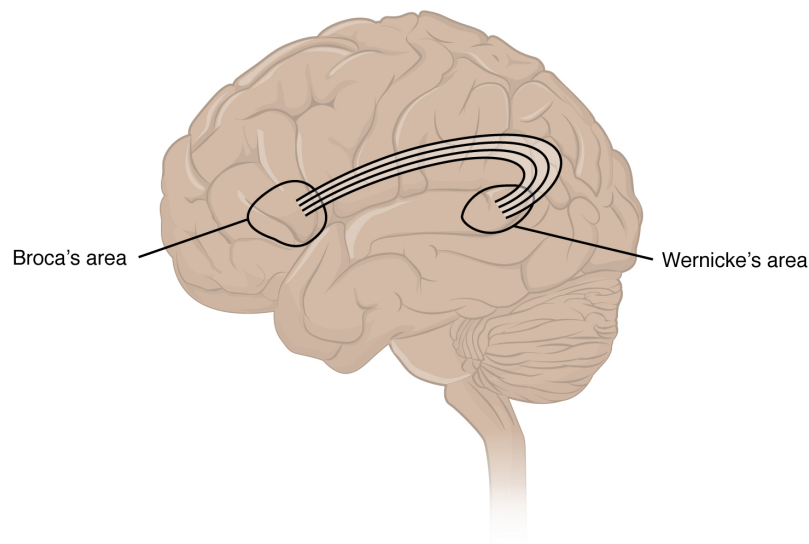
An important example of multimodal integrative areas is associated with language function ([\[link\]](#)). Adjacent to the auditory association cortex, at the end of the lateral sulcus just anterior to the visual cortex, is **Wernicke’s area**. In the lateral aspect of the frontal lobe, just anterior to the region of the motor cortex associated with the head and neck, is Broca’s area. Both regions were originally described on the basis of losses of speech and language, which is called **aphasia**. The aphasia associated with Broca’s area is known as an **expressive aphasia**, which means that speech production is compromised. This type of aphasia is often described as non-fluency because the ability to say some words leads to broken or halting speech. Grammar can also appear to be lost. The aphasia associated with Wernicke’s area is known as a **receptive aphasia**, which is not a loss of

speech production, but a loss of understanding of content. Patients, after recovering from acute forms of this aphasia, report not being able to understand what is said to them or what they are saying themselves, but they often cannot keep from talking.

The two regions are connected by white matter tracts that run between the posterior temporal lobe and the lateral aspect of the frontal lobe.

Conduction aphasia associated with damage to this connection refers to the problem of connecting the understanding of language to the production of speech. This is a very rare condition, but is likely to present as an inability to faithfully repeat spoken language.

Broca's and Wernicke's Areas



Two important integration areas of the cerebral cortex associated with language function are Broca's and Wernicke's areas.

The two areas are connected through the deep white matter running from the posterior temporal lobe to the frontal lobe.

Sensorium

Those parts of the brain involved in the reception and interpretation of sensory stimuli are referred to collectively as the sensorium. The cerebral cortex has several regions that are necessary for sensory perception. From the primary cortical areas of the somatosensory, visual, auditory, and gustatory senses to the association areas that process information in these modalities, the cerebral cortex is the seat of conscious sensory perception. In contrast, sensory information can also be processed by deeper brain regions, which we may vaguely describe as subconscious—for instance, we are not constantly aware of the proprioceptive information that the cerebellum uses to maintain balance. Several of the subtests can reveal activity associated with these sensory modalities, such as being able to hear a question or see a picture. Two subtests assess specific functions of these cortical areas.

The first is **praxis**, a practical exercise in which the patient performs a task completely on the basis of verbal description without any demonstration from the examiner. For example, the patient can be told to take their left hand and place it palm down on their left thigh, then flip it over so the palm is facing up, and then repeat this four times. The examiner describes the activity without any movements on their part to suggest how the movements are to be performed. The patient needs to understand the instructions, transform them into movements, and use sensory feedback, both visual and proprioceptive, to perform the movements correctly.

The second subtest for sensory perception is **gnosis**, which involves two tasks. The first task, known as **stereognosis**, involves the naming of objects strictly on the basis of the somatosensory information that comes from manipulating them. The patient keeps their eyes closed and is given a common object, such as a coin, that they have to identify. The patient should be able to indicate the particular type of coin, such as a dime versus a penny, or a nickel versus a quarter, on the basis of the sensory cues involved. For example, the size, thickness, or weight of the coin may be an indication, or to differentiate the pairs of coins suggested here, the smooth or corrugated edge of the coin will correspond to the particular denomination. The second task, **graphesthesia**, is to recognize numbers or letters written on the palm of the hand with a dull pointer, such as a pen cap.

Praxis and gnosis are related to the conscious perception and cortical processing of sensory information. Being able to transform verbal commands into a sequence of motor responses, or to manipulate and recognize a common object and associate it with a name for that object. Both subtests have language components because language function is integral to these functions. The relationship between the words that describe actions, or the nouns that represent objects, and the cerebral location of these concepts is suggested to be localized to particular cortical areas. Certain aphasias can be characterized by a deficit of verbs or nouns, known as V impairment or N impairment, or may be classified as V–N dissociation. Patients have difficulty using one type of word over the other. To describe what is happening in a photograph as part of the expressive language subtest, a patient will use active- or image-based language. The lack of one or the other of these components of language can relate to the ability to use verbs or nouns. Damage to the region at which the frontal and temporal lobes meet, including the region known as the insula, is associated with V impairment; damage to the middle and inferior temporal lobe is associated with N impairment.

Judgment and Abstract Reasoning

Planning and producing responses requires an ability to make sense of the world around us. Making judgments and reasoning in the abstract are necessary to produce movements as part of larger responses. For example, when your alarm goes off, do you hit the snooze button or jump out of bed? Is 10 extra minutes in bed worth the extra rush to get ready for your day? Will hitting the snooze button multiple times lead to feeling more rested or result in a panic as you run late? How you mentally process these questions can affect your whole day.

The prefrontal cortex is responsible for the functions responsible for planning and making decisions. In the mental status exam, the subtest that assesses judgment and reasoning is directed at three aspects of frontal lobe function. First, the examiner asks questions about problem solving, such as “If you see a house on fire, what would you do?” The patient is also asked to interpret common proverbs, such as “Don’t look a gift horse in the

mouth.” Additionally, pairs of words are compared for similarities, such as apple and orange, or lamp and cabinet.

The prefrontal cortex is composed of the regions of the frontal lobe that are not directly related to specific motor functions. The most posterior region of the frontal lobe, the precentral gyrus, is the primary motor cortex. Anterior to that are the premotor cortex, Broca’s area, and the frontal eye fields, which are all related to planning certain types of movements. Anterior to what could be described as motor association areas are the regions of the prefrontal cortex. They are the regions in which judgment, abstract reasoning, and working memory are localized. The antecedents to planning certain movements are judging whether those movements should be made, as in the example of deciding whether to hit the snooze button.

To an extent, the prefrontal cortex may be related to personality. The neurological exam does not necessarily assess personality, but it can be within the realm of neurology or psychiatry. A clinical situation that suggests this link between the prefrontal cortex and personality comes from the story of Phineas Gage, the railroad worker from the mid-1800s who had a metal spike impale his prefrontal cortex. There are suggestions that the steel rod led to changes in his personality. A man who was a quiet, dependable railroad worker became a raucous, irritable drunkard. Later anecdotal evidence from his life suggests that he was able to support himself, although he had to relocate and take on a different career as a stagecoach driver.

A psychiatric practice to deal with various disorders was the prefrontal lobotomy. This procedure was common in the 1940s and early 1950s, until antipsychotic drugs became available. The connections between the prefrontal cortex and other regions of the brain were severed. The disorders associated with this procedure included some aspects of what are now referred to as personality disorders, but also included mood disorders and psychoses. Depictions of lobotomies in popular media suggest a link between cutting the white matter of the prefrontal cortex and changes in a patient’s mood and personality, though this correlation is not well understood.

Note:**Everyday Connections****Left Brain, Right Brain**

Popular media often refer to right-brained and left-brained people, as if the brain were two independent halves that work differently for different people. This is a popular misinterpretation of an important neurological phenomenon. As an extreme measure to deal with a debilitating condition, the corpus callosum may be sectioned to overcome intractable epilepsy. When the connections between the two cerebral hemispheres are cut, interesting effects can be observed.

If a person with an intact corpus callosum is asked to put their hands in their pockets and describe what is there on the basis of what their hands feel, they might say that they have keys in their right pocket and loose change in the left. They may even be able to count the coins in their pocket and say if they can afford to buy a candy bar from the vending machine. If a person with a sectioned corpus callosum is given the same instructions, they will do something quite peculiar. They will only put their right hand in their pocket and say they have keys there. They will not even move their left hand, much less report that there is loose change in the left pocket.

The reason for this is that the language functions of the cerebral cortex are localized to the left hemisphere in 95 percent of the population.

Additionally, the left hemisphere is connected to the right side of the body through the corticospinal tract and the ascending tracts of the spinal cord. Motor commands from the precentral gyrus control the opposite side of the body, whereas sensory information processed by the postcentral gyrus is received from the opposite side of the body. For a verbal command to initiate movement of the right arm and hand, the left side of the brain needs to be connected by the corpus callosum. Language is processed in the left side of the brain and directly influences the left brain and right arm motor functions, but is sent to influence the right brain and left arm motor functions through the corpus callosum. Likewise, the left-handed sensory perception of what is in the left pocket travels across the corpus callosum from the right brain, so no verbal report on those contents would be possible if the hand happened to be in the pocket.

Note:

Watch the [video](#) titled “The Man With Two Brains” to see the neuroscientist Michael Gazzaniga introduce a patient he has worked with for years who has had his corpus callosum cut, separating his two cerebral hemispheres. A few tests are run to demonstrate how this manifests in tests of cerebral function. Unlike normal people, this patient can perform two independent tasks at the same time because the lines of communication between the right and left sides of his brain have been removed. Whereas a person with an intact corpus callosum cannot overcome the dominance of one hemisphere over the other, this patient can. If the left cerebral hemisphere is dominant in the majority of people, why would right-handedness be most common?

The Mental Status Exam

The cerebrum, particularly the cerebral cortex, is the location of important cognitive functions that are the focus of the mental status exam. The regionalization of the cortex, initially described on the basis of anatomical evidence of cytoarchitecture, reveals the distribution of functionally distinct areas. Cortical regions can be described as primary sensory or motor areas, association areas, or multimodal integration areas. The functions attributed to these regions include attention, memory, language, speech, sensation, judgment, and abstract reasoning.

The mental status exam addresses these cognitive abilities through a series of subtests designed to elicit particular behaviors ascribed to these functions. The loss of neurological function can illustrate the location of damage to the cerebrum. Memory functions are attributed to the temporal

lobe, particularly the medial temporal lobe structures known as the hippocampus and amygdala, along with the adjacent cortex. Evidence of the importance of these structures comes from the side effects of a bilateral temporal lobectomy that were studied in detail in patient HM.

Losses of language and speech functions, known as aphasias, are associated with damage to the important integration areas in the left hemisphere known as Broca's or Wernicke's areas, as well as the connections in the white matter between them. Different types of aphasia are named for the particular structures that are damaged. Assessment of the functions of the sensorium includes praxis and gnosis. The subtests related to these functions depend on multimodal integration, as well as language-dependent processing.

The prefrontal cortex contains structures important for planning, judgment, reasoning, and working memory. Damage to these areas can result in changes to personality, mood, and behavior. The famous case of Phineas Gage suggests a role for this cortex in personality, as does the outdated practice of prefrontal lobectomy.

Interactive Link Questions

Exercise:

Problem:

Read this [article](#) to learn about a young man who texts his fiancée in a panic as he finds that he is having trouble remembering things. At the hospital, a neurologist administers the mental status exam, which is mostly normal except for the three-word recall test. The young man could not recall them even 30 seconds after hearing them and repeating them back to the doctor. An undiscovered mass in the mediastinum region was found to be Hodgkin's lymphoma, a type of cancer that affects the immune system and likely caused antibodies to attack the nervous system. The patient eventually regained his ability to remember, though the events in the hospital were always elusive. Considering that the effects on memory were temporary, but resulted in the loss of the specific events of the hospital stay, what regions of the brain were likely to have been affected by the antibodies and what type of memory does that represent?

Solution:

The patient was unable to form episodic memories during the events described in the case, so the medial temporal lobe structures might have been affected by the antibodies.

Exercise:**Problem:**

Watch the [video](#) titled "The Man With Two Brains" to see the neuroscientist Michael Gazzaniga introduce a patient he has worked with for years who has had his corpus callosum cut, separating his two cerebral hemispheres. A few tests are run to demonstrate how this manifests in tests of cerebral function. Unlike normal people, this patient can perform two independent tasks at the same time because the lines of communication between the right and left sides of his brain have been removed. Whereas a person with an intact corpus callosum cannot overcome the dominance of one hemisphere over the other, this patient can. If the left cerebral hemisphere is dominant in the majority of people, why would right-handedness be most common?

Solution:

The left hemisphere of the cerebrum controls the right side of the body through the corticospinal tract. Because language function is largely associated with the dominant hemisphere, the hand with which a person writes will most likely be the one controlled by the left hemisphere.

Review Questions**Exercise:****Problem:**

Which of the following could be elements of cytoarchitecture, as related to Brodmann's microscopic studies of the cerebral cortex?

- a. connections to the cerebellum
- b. activation by visual stimuli
- c. number of neurons per square millimeter
- d. number of gyri or sulci

Solution:

C

Exercise:**Problem:**

Which of the following could be a multimodal integrative area?

- a. primary visual cortex
- b. premotor cortex
- c. hippocampus
- d. Wernicke's area

Solution:

D

Exercise:

Problem: Which is an example of episodic memory?

- a. how to bake a cake
- b. your last birthday party
- c. how old you are
- d. needing to wear an oven mitt to take a cake out of the oven

Solution:

B

Exercise:

Problem:

Which type of aphasia is more like hearing a foreign language spoken?

- a. receptive aphasia
- b. expressive aphasia
- c. conductive aphasia
- d. Broca's aphasia

Solution:

A

Exercise:

Problem:

What region of the cerebral cortex is associated with understanding language, both from another person and the language a person generates himself or herself?

- a. medial temporal lobe
- b. ventromedial prefrontal cortex
- c. superior temporal gyrus
- d. postcentral gyrus

Solution:

C

Critical Thinking Questions**Exercise:****Problem:**

A patient's performance of the majority of the mental status exam subtests is in line with the expected norms, but the patient cannot repeat a string of numbers given by the examiner. What is a likely explanation?

Solution:

The patient has suffered a stroke to the prefrontal cortex where working memory is localized.

Exercise:

Problem:

A patient responds to the question “What is your name?” with a look of incomprehension. Which of the two major language areas is most likely affected and what is the name for that type of aphasia?

Solution:

Wernicke’s area is associated with the comprehension of language, so the person probably doesn’t understand the question being asked and cannot respond meaningfully. This is called a receptive aphasia.

Glossary

anterograde amnesia

inability to form new memories from a particular time forward

aphasia

loss of language function

conduction aphasia

loss of language function related to connecting the understanding of speech with the production of speech, without either specific function being lost

cytoarchitecture

study of a tissue based on the structure and organization of its cellular components; related to the broader term, histology

episodic memory

memory of specific events in an autobiographical sense

expressive aphasia

loss of the ability to produce language; usually associated with damage to Broca’s area in the frontal lobe

gnosis

in a neurological exam, intuitive experiential knowledge tested by interacting with common objects or symbols

graphesthesia

perception of symbols, such as letters or numbers, traced in the palm of the hand

praxis

in a neurological exam, the act of doing something using ready knowledge or skills in response to verbal instruction

procedural memory

memory of how to perform a specific task

receptive aphasia

loss of the ability to understand received language, such as what is spoken to the subject or given in written form

retrograde amnesia

loss of memories before a particular event

short-term memory

capacity to retain information actively in the brain for a brief period of time

stereognosis

perception of common objects placed in the hand solely on the basis of manipulation of that object in the hand

Wernicke's area

region at the posterior end of the lateral sulcus in which speech comprehension is localized

The Cranial Nerve Exam

By the end of this section, you will be able to:

- Describe the functional grouping of cranial nerves
- Match the regions of the forebrain and brain stem that are connected to each cranial nerve
- Suggest diagnoses that would explain certain losses of function in the cranial nerves
- Relate cranial nerve deficits to damage of adjacent, unrelated structures

The twelve cranial nerves are typically covered in introductory anatomy courses, and memorizing their names is facilitated by numerous mnemonics developed by students over the years of this practice. But knowing the names of the nerves in order often leaves much to be desired in understanding what the nerves do. The nerves can be categorized by functions, and subtests of the cranial nerve exam can clarify these functional groupings.

Three of the nerves are strictly responsible for special senses whereas four others contain fibers for special and general senses. Three nerves are connected to the extraocular muscles resulting in the control of gaze. Four nerves connect to muscles of the face, oral cavity, and pharynx, controlling facial expressions, mastication, swallowing, and speech. Four nerves make up the cranial component of the parasympathetic nervous system responsible for pupillary constriction, salivation, and the regulation of the organs of the thoracic and upper abdominal cavities. Finally, one nerve controls the muscles of the neck, assisting with spinal control of the movement of the head and neck.

The cranial nerve exam allows directed tests of forebrain and brain stem structures. The twelve cranial nerves serve the head and neck. The vagus nerve (cranial nerve X) has autonomic functions in the thoracic and superior abdominal cavities. The special senses are served through the cranial nerves, as well as the general senses of the head and neck. The movement of the eyes, face, tongue, throat, and neck are all under the control of cranial nerves. Preganglionic parasympathetic nerve fibers that control pupillary size, salivary glands, and the thoracic and upper abdominal viscera are

found in four of the nerves. Tests of these functions can provide insight into damage to specific regions of the brain stem and may uncover deficits in adjacent regions.

Sensory Nerves

The olfactory, optic, and vestibulocochlear nerves (cranial nerves I, II, and VIII) are dedicated to four of the special senses: smell, vision, equilibrium, and hearing, respectively. Taste sensation is relayed to the brain stem through fibers of the facial and glossopharyngeal nerves. The trigeminal nerve is a mixed nerve that carries the general somatic senses from the head, similar to those coming through spinal nerves from the rest of the body.

Testing smell is straightforward, as common smells are presented to one nostril at a time. The patient should be able to recognize the smell of coffee or mint, indicating the proper functioning of the olfactory system. Loss of the sense of smell is called anosmia and can be lost following blunt trauma to the head or through aging. The short axons of the first cranial nerve regenerate on a regular basis. The neurons in the olfactory epithelium have a limited life span, and new cells grow to replace the ones that die off. The axons from these neurons grow back into the CNS by following the existing axons—representing one of the few examples of such growth in the mature nervous system. If all of the fibers are sheared when the brain moves within the cranium, such as in a motor vehicle accident, then no axons can find their way back to the olfactory bulb to re-establish connections. If the nerve is not completely severed, the anosmia may be temporary as new neurons can eventually reconnect.

Olfaction is not the pre-eminent sense, but its loss can be quite detrimental. The enjoyment of food is largely based on our sense of smell. Anosmia means that food will not seem to have the same taste, though the gustatory sense is intact, and food will often be described as being bland. However, the taste of food can be improved by adding ingredients (e.g., salt) that stimulate the gustatory sense.

Testing vision relies on the tests that are common in an optometry office. The **Snellen chart** ([link](#)) demonstrates visual acuity by presenting standard Roman letters in a variety of sizes. The result of this test is a rough generalization of the acuity of a person based on the normal accepted acuity, such that a letter that subtends a visual angle of 5 minutes of an arc at 20 feet can be seen. To have 20/60 vision, for example, means that the smallest letters that a person can see at a 20-foot distance could be seen by a person with normal acuity from 60 feet away. Testing the extent of the visual field means that the examiner can establish the boundaries of peripheral vision as simply as holding their hands out to either side and asking the patient when the fingers are no longer visible without moving the eyes to track them. If it is necessary, further tests can establish the perceptions in the visual fields. Physical inspection of the optic disk, or where the optic nerve emerges from the eye, can be accomplished by looking through the pupil with an ophthalmoscope.

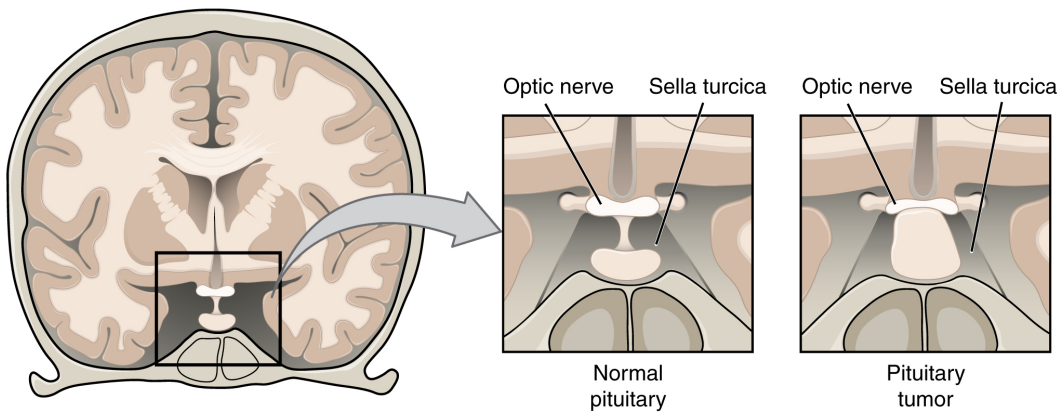
The Snellen Chart

E	1	20/200
F P	2	20/100
T O Z	3	20/70
L P E D	4	20/50
P E C F D	5	20/40
E D F C Z P	6	20/30
F E L O P Z D	7	20/25
D E F P O T E C	8	20/20
L E F O D P C T	9	
F D P L T C E O	10	
P E Z O L C F T D	11	

The Snellen chart for visual acuity presents a limited number of Roman letters in lines of decreasing size. The line with letters that subtend 5 minutes of an arc from 20 feet represents the smallest letters that a person with normal acuity should be able to read at that distance. The different sizes of letters in the other lines represent rough approximations of what a person of normal acuity can read at different distances. For example, the line that represents 20/200 vision would have larger letters so that they are legible to the person with normal acuity at 200 feet.

The optic nerves from both sides enter the cranium through the respective optic canals and meet at the optic chiasm at which fibers sort such that the two halves of the visual field are processed by the opposite sides of the brain. Deficits in visual field perception often suggest damage along the length of the optic pathway between the orbit and the diencephalon. For example, loss of peripheral vision may be the result of a pituitary tumor pressing on the optic chiasm ([link](#)). The pituitary, seated in the sella turcica of the sphenoid bone, is directly inferior to the optic chiasm. The axons that decussate in the chiasm are from the medial retinae of either eye, and therefore carry information from the peripheral visual field.

Pituitary Tumor



The pituitary gland is located in the sella turcica of the sphenoid bone within the cranial floor, placing it immediately inferior to the optic chiasm. If the pituitary gland develops a tumor, it can press against the fibers crossing in the chiasm. Those fibers are conveying peripheral visual information to the opposite side of the brain, so the patient will experience “tunnel vision”—meaning that only the central visual field will be perceived.

The vestibulocochlear nerve (CN VIII) carries both equilibrium and auditory sensations from the inner ear to the medulla. Though the two senses are not directly related, anatomy is mirrored in the two systems. Problems with balance, such as vertigo, and deficits in hearing may both point to problems with the inner ear. Within the petrous region of the temporal bone is the bony labyrinth of the inner ear. The vestibule is the portion for equilibrium, composed of the utricle, saccule, and the three semicircular canals. The cochlea is responsible for transducing sound waves into a neural signal. The sensory nerves from these two structures travel side-by-side as the vestibulocochlear nerve, though they are really separate divisions. They both emerge from the inner ear, pass through the internal auditory meatus, and synapse in nuclei of the superior medulla. Though they are part of distinct sensory systems, the vestibular nuclei and the cochlear nuclei are close neighbors with adjacent inputs. Deficits in one or both systems could occur from damage that encompasses structures close to

both. Damage to structures near the two nuclei can result in deficits to one or both systems.

Balance or hearing deficits may be the result of damage to the middle or inner ear structures. Ménière's disease is a disorder that can affect both equilibrium and audition in a variety of ways. The patient can suffer from vertigo, a low-frequency ringing in the ears, or a loss of hearing. From patient to patient, the exact presentation of the disease can be different. Additionally, within a single patient, the symptoms and signs may change as the disease progresses. Use of the neurological exam subtests for the vestibulocochlear nerve illuminates the changes a patient may go through. The disease appears to be the result of accumulation, or over-production, of fluid in the inner ear, in either the vestibule or cochlea.

Tests of equilibrium are important for coordination and gait and are related to other aspects of the neurological exam. The vestibulo-ocular reflex involves the cranial nerves for gaze control. Balance and equilibrium, as tested by the Romberg test, are part of spinal and cerebellar processes and involved in those components of the neurological exam, as discussed later.

Hearing is tested by using a tuning fork in a couple of different ways. The **Rinne test** involves using a tuning fork to distinguish between **conductive hearing** and **sensorineural hearing**. Conductive hearing relies on vibrations being conducted through the ossicles of the middle ear. Sensorineural hearing is the transmission of sound stimuli through the neural components of the inner ear and cranial nerve. A vibrating tuning fork is placed on the mastoid process and the patient indicates when the sound produced from this is no longer present. Then the fork is immediately moved to just next to the ear canal so the sound travels through the air. If the sound is not heard through the ear, meaning the sound is conducted better through the temporal bone than through the ossicles, a conductive hearing deficit is present. The **Weber test** also uses a tuning fork to differentiate between conductive versus sensorineural hearing loss. In this test, the tuning fork is placed at the top of the skull, and the sound of the tuning fork reaches both inner ears by travelling through bone. In a healthy patient, the sound would appear equally loud in both ears. With unilateral conductive hearing loss, however, the tuning fork sounds louder in the ear

with hearing loss. This is because the sound of the tuning fork has to compete with background noise coming from the outer ear, but in conductive hearing loss, the background noise is blocked in the damaged ear, allowing the tuning fork to sound relatively louder in that ear. With unilateral sensorineural hearing loss, however, damage to the cochlea or associated nervous tissue means that the tuning fork sounds quieter in that ear.

The trigeminal system of the head and neck is the equivalent of the ascending spinal cord systems of the dorsal column and the spinothalamic pathways. Somatosensation of the face is conveyed along the nerve to enter the brain stem at the level of the pons. Synapses of those axons, however, are distributed across nuclei found throughout the brain stem. The mesencephalic nucleus processes proprioceptive information of the face, which is the movement and position of facial muscles. It is the sensory component of the **jaw-jerk reflex**, a stretch reflex of the masseter muscle. The chief nucleus, located in the pons, receives information about light touch as well as proprioceptive information about the mandible, which are both relayed to the thalamus and, ultimately, to the postcentral gyrus of the parietal lobe. The spinal trigeminal nucleus, located in the medulla, receives information about crude touch, pain, and temperature to be relayed to the thalamus and cortex. Essentially, the projection through the chief nucleus is analogous to the dorsal column pathway for the body, and the projection through the spinal trigeminal nucleus is analogous to the spinothalamic pathway.

Subtests for the sensory component of the trigeminal system are the same as those for the sensory exam targeting the spinal nerves. The primary sensory subtest for the trigeminal system is sensory discrimination. A cotton-tipped applicator, which is cotton attached to the end of a thin wooden stick, can be used easily for this. The wood of the applicator can be snapped so that a pointed end is opposite the soft cotton-tipped end. The cotton end provides a touch stimulus, while the pointed end provides a painful, or sharp, stimulus. While the patient's eyes are closed, the examiner touches the two ends of the applicator to the patient's face, alternating randomly between them. The patient must identify whether the stimulus is sharp or dull. These stimuli are processed by the trigeminal system separately. Contact with the

cotton tip of the applicator is a light touch, relayed by the chief nucleus, but contact with the pointed end of the applicator is a painful stimulus relayed by the spinal trigeminal nucleus. Failure to discriminate these stimuli can localize problems within the brain stem. If a patient cannot recognize a painful stimulus, that might indicate damage to the spinal trigeminal nucleus in the medulla. The medulla also contains important regions that regulate the cardiovascular, respiratory, and digestive systems, as well as being the pathway for ascending and descending tracts between the brain and spinal cord. Damage, such as a stroke, that results in changes in sensory discrimination may indicate these unrelated regions are affected as well.

Gaze Control

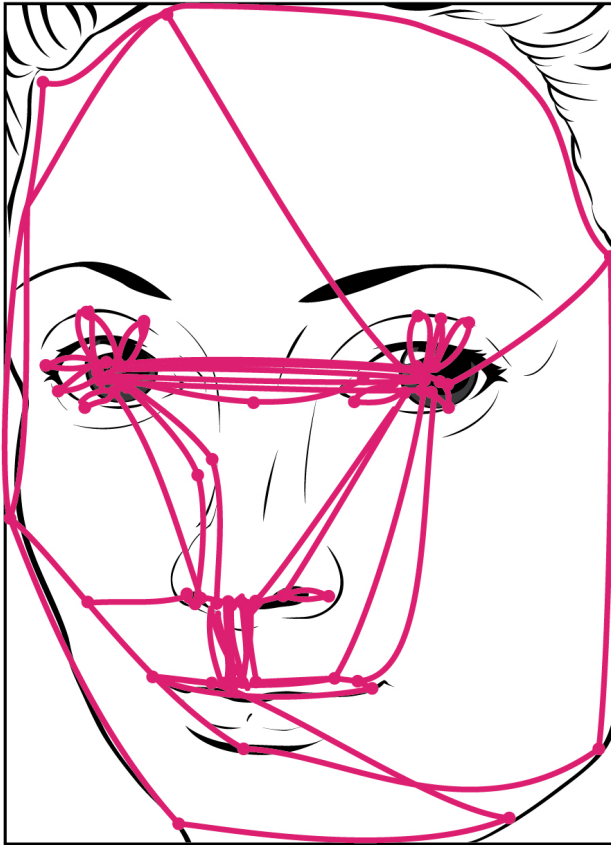
The three nerves that control the extraocular muscles are the oculomotor, trochlear, and abducens nerves, which are the third, fourth, and sixth cranial nerves. As the name suggests, the abducens nerve is responsible for abducting the eye, which it controls through contraction of the lateral rectus muscle. The trochlear nerve controls the superior oblique muscle to rotate the eye along its axis in the orbit medially, which is called **intorsion**, and is a component of focusing the eyes on an object close to the face. The oculomotor nerve controls all the other extraocular muscles, as well as a muscle of the upper eyelid. Movements of the two eyes need to be coordinated to locate and track visual stimuli accurately. When moving the eyes to locate an object in the horizontal plane, or to track movement horizontally in the visual field, the lateral rectus muscle of one eye and medial rectus muscle of the other eye are both active. The lateral rectus is controlled by neurons of the abducens nucleus in the superior medulla, whereas the medial rectus is controlled by neurons in the oculomotor nucleus of the midbrain.

Coordinated movement of both eyes through different nuclei requires integrated processing through the brain stem. In the midbrain, the superior colliculus integrates visual stimuli with motor responses to initiate eye movements. The **paramedian pontine reticular formation (PPRF)** will initiate a rapid eye movement, or **saccade**, to bring the eyes to bear on a visual stimulus quickly. These areas are connected to the oculomotor, trochlear, and abducens nuclei by the **medial longitudinal fasciculus**

(**MLF**) that runs through the majority of the brain stem. The MLF allows for **conjugate gaze**, or the movement of the eyes in the same direction, during horizontal movements that require the lateral and medial rectus muscles. Control of conjugate gaze strictly in the vertical direction is contained within the oculomotor complex. To elevate the eyes, the oculomotor nerve on either side stimulates the contraction of both superior rectus muscles; to depress the eyes, the oculomotor nerve on either side stimulates the contraction of both inferior rectus muscles.

Purely vertical movements of the eyes are not very common. Movements are often at an angle, so some horizontal components are necessary, adding the medial and lateral rectus muscles to the movement. The rapid movement of the eyes used to locate and direct the fovea onto visual stimuli is called a saccade. Notice that the paths that are traced in [\[link\]](#) are not strictly vertical. The movements between the nose and the mouth are closest, but still have a slant to them. Also, the superior and inferior rectus muscles are not perfectly oriented with the line of sight. The origin for both muscles is medial to their insertions, so elevation and depression may require the lateral rectus muscles to compensate for the slight adduction inherent in the contraction of those muscles, requiring MLF activity as well.

Saccadic Eye Movements



Saccades are rapid, conjugate movements of the eyes to survey a complicated visual stimulus, or to follow a moving visual stimulus. This image represents the shifts in gaze typical of a person studying a face. Notice the concentration of gaze on the major features of the face and the large number of paths traced between the eyes or around the mouth.

Testing eye movement is simply a matter of having the patient track the tip of a pen as it is passed through the visual field. This may appear similar to testing visual field deficits related to the optic nerve, but the difference is

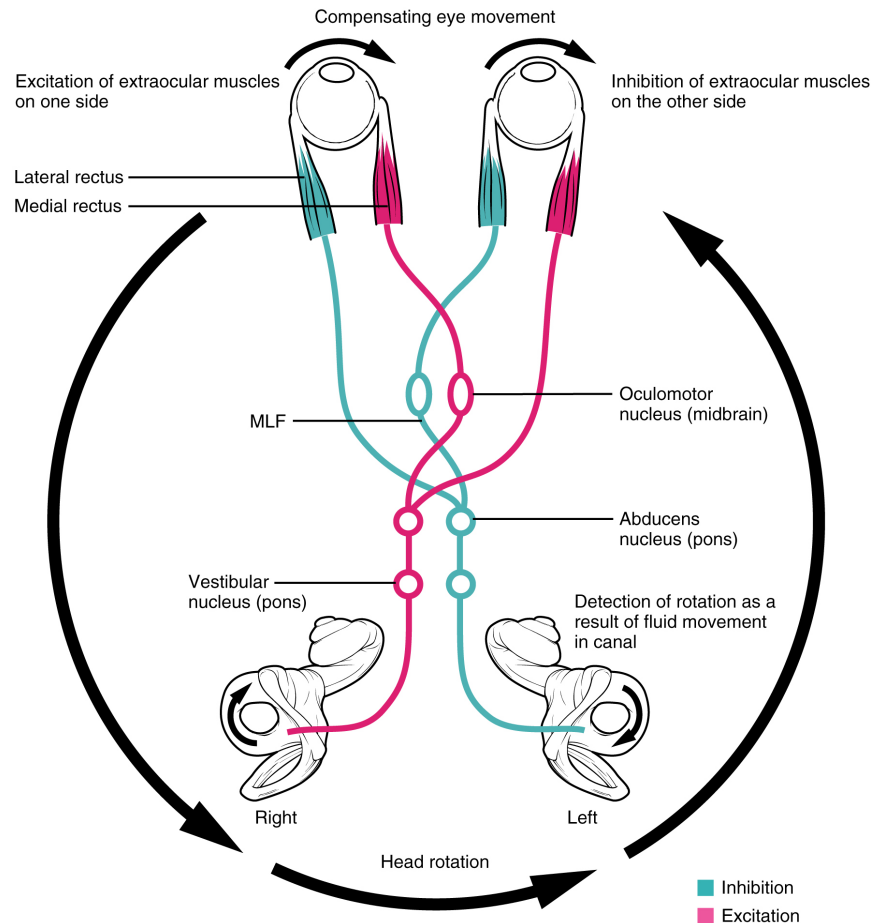
that the patient is asked to not move the eyes while the examiner moves a stimulus into the peripheral visual field. Here, the extent of movement is the point of the test. The examiner is watching for conjugate movements representing proper function of the related nuclei and the MLF. Failure of one eye to abduct while the other adducts in a horizontal movement is referred to as **internuclear ophthalmoplegia**. When this occurs, the patient will experience **diplopia**, or double vision, as the two eyes are temporarily pointed at different stimuli. Diplopia is not restricted to failure of the lateral rectus, because any of the extraocular muscles may fail to move one eye in perfect conjugation with the other.

The final aspect of testing eye movements is to move the tip of the pen in toward the patient's face. As visual stimuli move closer to the face, the two medial recti muscles cause the eyes to move in the one nonconjugate movement that is part of gaze control. When the two eyes move to look at something closer to the face, they both adduct, which is referred to as **convergence**. To keep the stimulus in focus, the eye also needs to change the shape of the lens, which is controlled through the parasympathetic fibers of the oculomotor nerve. The change in focal power of the eye is referred to as **accommodation**. Accommodation ability changes with age; focusing on nearer objects, such as the written text of a book or on a computer screen, may require corrective lenses later in life. Coordination of the skeletal muscles for convergence and coordination of the smooth muscles of the ciliary body for accommodation are referred to as the **accommodation–convergence reflex**.

A crucial function of the cranial nerves is to keep visual stimuli centered on the fovea of the retina. The **vestibulo-ocular reflex (VOR)** coordinates all of the components ([\[link\]](#)), both sensory and motor, that make this possible. If the head rotates in one direction—for example, to the right—the horizontal pair of semicircular canals in the inner ear indicate the movement by increased activity on the right and decreased activity on the left. The information is sent to the abducens nuclei and oculomotor nuclei on either side to coordinate the lateral and medial rectus muscles. The left lateral rectus and right medial rectus muscles will contract, rotating the eyes in the opposite direction of the head, while nuclei controlling the right lateral rectus and left medial rectus muscles will be inhibited to reduce antagonism

of the contracting muscles. These actions stabilize the visual field by compensating for the head rotation with opposite rotation of the eyes in the orbits. Deficits in the VOR may be related to vestibular damage, such as in Ménière's disease, or from dorsal brain stem damage that would affect the eye movement nuclei or their connections through the MLF.

Vestibulo-ocular Reflex



If the head is turned in one direction, the coordination of that movement with the fixation of the eyes on a visual stimulus involves a circuit that ties the vestibular sense with the eye movement nuclei through the MLF.

Nerves of the Face and Oral Cavity

An iconic part of a doctor's visit is the inspection of the oral cavity and pharynx, suggested by the directive to "open your mouth and say 'ah.'" This is followed by inspection, with the aid of a tongue depressor, of the back of the mouth, or the opening of the oral cavity into the pharynx known as the **fauces**. Whereas this portion of a medical exam inspects for signs of infection, such as in tonsillitis, it is also the means to test the functions of the cranial nerves that are associated with the oral cavity.

The facial and glossopharyngeal nerves convey gustatory stimulation to the brain. Testing this is as simple as introducing salty, sour, bitter, or sweet stimuli to either side of the tongue. The patient should respond to the taste stimulus before retracting the tongue into the mouth. Stimuli applied to specific locations on the tongue will dissolve into the saliva and may stimulate taste buds connected to either the left or right of the nerves, masking any lateral deficits. Along with taste, the glossopharyngeal nerve relays general sensations from the pharyngeal walls. These sensations, along with certain taste stimuli, can stimulate the gag reflex. If the examiner moves the tongue depressor to contact the lateral wall of the fauces, this should elicit the gag reflex. Stimulation of either side of the fauces should elicit an equivalent response. The motor response, through contraction of the muscles of the pharynx, is mediated through the vagus nerve. Normally, the vagus nerve is considered autonomic in nature. The vagus nerve directly stimulates the contraction of skeletal muscles in the pharynx and larynx to contribute to the swallowing and speech functions. Further testing of vagus motor function has the patient repeating consonant sounds that require movement of the muscles around the fauces. The patient is asked to say "lah-kah-pah" or a similar set of alternating sounds while the examiner observes the movements of the soft palate and arches between the palate and tongue.

The facial and glossopharyngeal nerves are also responsible for the initiation of salivation. Neurons in the salivary nuclei of the medulla project through these two nerves as preganglionic fibers, and synapse in ganglia located in the head. The parasympathetic fibers of the facial nerve synapse in the pterygopalatine ganglion, which projects to the submandibular gland and sublingual gland. The parasympathetic fibers of the glossopharyngeal nerve synapse in the otic ganglion, which projects to the parotid gland.

Salivation in response to food in the oral cavity is based on a visceral reflex arc within the facial or glossopharyngeal nerves. Other stimuli that stimulate salivation are coordinated through the hypothalamus, such as the smell and sight of food.

The hypoglossal nerve is the motor nerve that controls the muscles of the tongue, except for the palatoglossus muscle, which is controlled by the vagus nerve. There are two sets of muscles of the tongue. The **extrinsic muscles of the tongue** are connected to other structures, whereas the **intrinsic muscles of the tongue** are completely contained within the lingual tissues. While examining the oral cavity, movement of the tongue will indicate whether hypoglossal function is impaired. The test for hypoglossal function is the “stick out your tongue” part of the exam. The genioglossus muscle is responsible for protrusion of the tongue. If the hypoglossal nerves on both sides are working properly, then the tongue will stick straight out. If the nerve on one side has a deficit, the tongue will stick out to that side—pointing to the side with damage. Loss of function of the tongue can interfere with speech and swallowing. Additionally, because the location of the hypoglossal nerve and nucleus is near the cardiovascular center, inspiratory and expiratory areas for respiration, and the vagus nuclei that regulate digestive functions, a tongue that protrudes incorrectly can suggest damage in adjacent structures that have nothing to do with controlling the tongue.

Note:



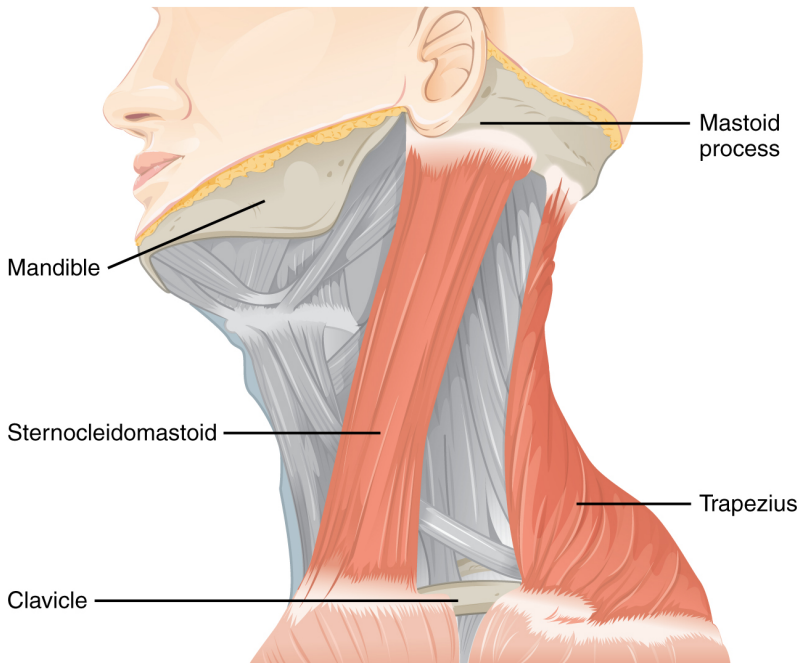
Watch this short [video](#) to see an examination of the facial nerve using some simple tests. The facial nerve controls the muscles of facial expression. Severe deficits will be obvious in watching someone use those muscles for normal control. One side of the face might not move like the other side.

But directed tests, especially for contraction against resistance, require a formal testing of the muscles. The muscles of the upper and lower face need to be tested. The strength test in this video involves the patient squeezing her eyes shut and the examiner trying to pry her eyes open. Why does the examiner ask her to try a second time?

Motor Nerves of the Neck

The accessory nerve, also referred to as the spinal accessory nerve, innervates the sternocleidomastoid and trapezius muscles ([\[link\]](#)). When both the sternocleidomastoids contract, the head flexes forward; individually, they cause rotation to the opposite side. The trapezius can act as an antagonist, causing extension and hyperextension of the neck. These two superficial muscles are important for changing the position of the head. Both muscles also receive input from cervical spinal nerves. Along with the spinal accessory nerve, these nerves contribute to elevating the scapula and clavicle through the trapezius, which is tested by asking the patient to shrug both shoulders, and watching for asymmetry. For the sternocleidomastoid, those spinal nerves are primarily sensory projections, whereas the trapezius also has lateral insertions to the clavicle and scapula, and receives motor input from the spinal cord. Calling the nerve the spinal accessory nerve suggests that it is aiding the spinal nerves. Though that is not precisely how the name originated, it does help make the association between the function of this nerve in controlling these muscles and the role these muscles play in movements of the trunk or shoulders.

Muscles Controlled by the Accessory Nerve



The accessory nerve innervates the sternocleidomastoid and trapezius muscles, both of which attach to the head and to the trunk and shoulders. They can act as antagonists in head flexion and extension, and as synergists in lateral flexion toward the shoulder.

To test these muscles, the patient is asked to flex and extend the neck or shrug the shoulders against resistance, testing the strength of the muscles. Lateral flexion of the neck toward the shoulder tests both at the same time. Any difference on one side versus the other would suggest damage on the weaker side. These strength tests are common for the skeletal muscles controlled by spinal nerves and are a significant component of the motor exam. Deficits associated with the accessory nerve may have an effect on orienting the head, as described with the VOR.

Note:

Homeostatic Imbalances

The Pupillary Light Response

The autonomic control of pupillary size in response to a bright light involves the sensory input of the optic nerve and the parasympathetic motor output of the oculomotor nerve. When light hits the retina, specialized photosensitive ganglion cells send a signal along the optic nerve to the pretectal nucleus in the superior midbrain. A neuron from this nucleus projects to the Edinger–Westphal nuclei in the oculomotor complex in both sides of the midbrain. Neurons in this nucleus give rise to the preganglionic parasympathetic fibers that project through the oculomotor nerve to the ciliary ganglion in the posterior orbit. The postganglionic parasympathetic fibers from the ganglion project to the iris, where they release acetylcholine onto circular fibers that constrict the pupil to reduce the amount of light hitting the retina. The sympathetic nervous system is responsible for dilating the pupil when light levels are low. Shining light in one eye will elicit constriction of both pupils. The efferent limb of the pupillary light reflex is bilateral. Light shined in one eye causes a constriction of that pupil, as well as constriction of the contralateral pupil. Shining a penlight in the eye of a patient is a very artificial situation, as both eyes are normally exposed to the same light sources. Testing this reflex can illustrate whether the optic nerve or the oculomotor nerve is damaged. If shining the light in one eye results in no changes in pupillary size but shining light in the opposite eye elicits a normal, bilateral response, the damage is associated with the optic nerve on the nonresponsive side. If light in either eye elicits a response in only one eye, the problem is with the oculomotor system.

If light in the right eye only causes the left pupil to constrict, the direct reflex is lost and the consensual reflex is intact, which means that the right oculomotor nerve (or Edinger–Westphal nucleus) is damaged. Damage to the right oculomotor connections will be evident when light is shined in the left eye. In that case, the direct reflex is intact but the consensual reflex is lost, meaning that the left pupil will constrict while the right does not.

The Cranial Nerve Exam

The cranial nerves can be separated into four major groups associated with the subtests of the cranial nerve exam. First are the sensory nerves, then the nerves that control eye movement, the nerves of the oral cavity and superior pharynx, and the nerve that controls movements of the neck.

The olfactory, optic, and vestibulocochlear nerves are strictly sensory nerves for smell, sight, and balance and hearing, whereas the trigeminal, facial, and glossopharyngeal nerves carry somatosensation of the face, and taste—separated between the anterior two-thirds of the tongue and the posterior one-third. Special senses are tested by presenting the particular stimuli to each receptive organ. General senses can be tested through sensory discrimination of touch versus painful stimuli.

The oculomotor, trochlear, and abducens nerves control the extraocular muscles and are connected by the medial longitudinal fasciculus to coordinate gaze. Testing conjugate gaze is as simple as having the patient follow a visual target, like a pen tip, through the visual field ending with an approach toward the face to test convergence and accommodation. Along with the vestibular functions of the eighth nerve, the vestibulo-ocular reflex stabilizes gaze during head movements by coordinating equilibrium sensations with the eye movement systems.

The trigeminal nerve controls the muscles of chewing, which are tested for stretch reflexes. Motor functions of the facial nerve are usually obvious if facial expressions are compromised, but can be tested by having the patient raise their eyebrows, smile, and frown. Movements of the tongue, soft palate, or superior pharynx can be observed directly while the patient swallows, while the gag reflex is elicited, or while the patient says repetitive consonant sounds. The motor control of the gag reflex is largely controlled by fibers in the vagus nerve and constitutes a test of that nerve because the parasympathetic functions of that nerve are involved in visceral regulation, such as regulating the heartbeat and digestion.

Movement of the head and neck using the sternocleidomastoid and trapezius muscles is controlled by the accessory nerve. Flexing of the neck and strength testing of those muscles reviews the function of that nerve.

Interactive Link Questions

Exercise:

Problem:

Watch this short [video](#) to see an examination of the facial nerve using some simple tests. The facial nerve controls the muscles of facial expression. Severe deficits will be obvious in watching someone use those muscles for normal control. One side of the face might not move like the other side. But directed tests, especially for contraction against resistance, require a formal testing of the muscles. The muscles of the upper and lower face need to be tested. The strength test in this video involves the patient squeezing her eyes shut and the examiner trying to pry her eyes open. Why does the examiner ask her to try a second time?

Solution:

She has just demonstrated voluntary control by closing her eyes, but when he provides the resistance that she needs to hold tight against, she has already relaxed the muscles enough for him to pull them open. She needs to squeeze them tighter to demonstrate the strength she has in the orbicular oculi.

Review Questions

Exercise:

Problem:

Without olfactory sensation to complement gustatory stimuli, food will taste bland unless it is seasoned with which substance?

- a. salt
- b. thyme
- c. garlic
- d. olive oil

Solution:

A

Exercise:

Problem:

Which of the following cranial nerves is *not* part of the VOR?

- a. optic
- b. oculomotor
- c. abducens
- d. vestibulocochlear

Solution:

A

Exercise:

Problem:

Which nerve is responsible for controlling the muscles that result in the gag reflex?

- a. trigeminal
- b. facial
- c. glossopharyngeal
- d. vagus

Solution:

D

Exercise:

Problem:

Which nerve is responsible for taste, as well as salivation, in the anterior oral cavity?

- a. facial
- b. glossopharyngeal
- c. vagus
- d. hypoglossal

Solution:

A

Exercise:**Problem:**

Which of the following nerves controls movements of the neck?

- a. oculomotor
- b. vestibulocochlear
- c. spinal accessory
- d. hypoglossal

Solution:

C

Critical Thinking Questions**Exercise:**

Problem:

As a person ages, their ability to focus on near objects (accommodation) changes. If a person is already myopic (near-sighted), why would corrective lenses not be necessary to read a book or computer screen?

Solution:

If the person already has problems focusing on far objects, and wears corrective lenses to see farther objects, then as accommodation changes, focusing on a reading surface might still be in their naturally near-sighted range.

Exercise:**Problem:**

When a patient flexes their neck, the head tips to the right side. Also, their tongue sticks out slightly to the left when they try to stick it straight out. Where is the damage to the brain stem most likely located?

Solution:

The medulla is where the accessory nerve, which controls the sternocleidomastoid muscle, and the hypoglossal nerve, which controls the genioglossus muscle, are both located. The weakness of the left side of the neck, and the tendency of the tongue to point to that side, both show that the damage is on the left side of the brain stem.

Glossary

accommodation

in vision, a change in the ability of the eye to focus on objects at different distances

accommodation–convergence reflex

coordination of somatic control of the medial rectus muscles of either eye with the parasympathetic control of the ciliary bodies to maintain focus while the eyes converge on visual stimuli near to the face

conductive hearing

hearing dependent on the conduction of vibrations of the tympanic membrane through the ossicles of the middle ear

conjugate gaze

coordinated movement of the two eyes simultaneously in the same direction

convergence

in vision, the movement of the eyes so that they are both pointed at the same point in space, which increases for stimuli that are closer to the subject

diplopia

double vision resulting from a failure in conjugate gaze

extrinsic muscles of the tongue

muscles that are connected to other structures, such as the hyoid bone or the mandible, and control the position of the tongue

fauces

opening from the oral cavity into the pharynx

internuclear ophthalmoplegia

deficit of conjugate lateral gaze because the lateral rectus muscle of one eye does not contract resulting from damage to the abducens nerve or the MLF

intorsion

medial rotation of the eye around its axis

intrinsic muscles of the tongue

muscles that originate out of, and insert into, other tissues within the tongue and control the shape of the tongue

jaw-jerk reflex

stretch reflex of the masseter muscle

medial longitudinal fasciculus (MLF)

fiber pathway that connects structures involved in the control of eye and head position, from the superior colliculus to the vestibular nuclei and cerebellum

paramedian pontine reticular formation (PPRF)

region of the brain stem adjacent to the motor nuclei for gaze control that coordinates rapid, conjugate eye movements

Rinne test

use of a tuning fork to test conductive hearing loss versus sensorineural hearing loss

saccade

small, rapid movement of the eyes used to locate and direct the fovea onto visual stimuli

sensorineural hearing

hearing dependent on the transduction and propagation of auditory information through the neural components of the peripheral auditory structures

Snellen chart

standardized arrangement of letters in decreasing size presented to a subject at a distance of 20 feet to test visual acuity

vestibulo-ocular reflex (VOR)

reflex based on connections between the vestibular system and the cranial nerves of eye movements that ensures that images are stabilized on the retina as the head and body move

Weber test

use of a tuning fork to test the laterality of hearing loss by placing it at several locations on the midline of the skull

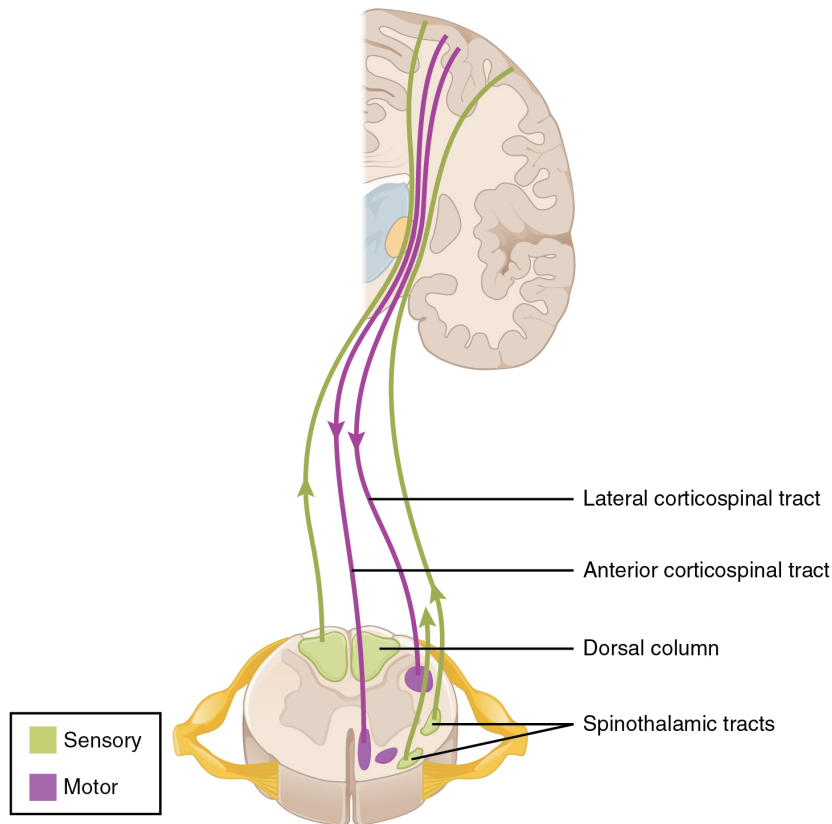
The Sensory and Motor Exams

By the end of this section, you will be able to:

- Describe the arrangement of sensory and motor regions in the spinal cord
- Relate damage in the spinal cord to sensory or motor deficits
- Differentiate between upper motor neuron and lower motor neuron diseases
- Describe the clinical indications of common reflexes

Connections between the body and the CNS occur through the spinal cord. The cranial nerves connect the head and neck directly to the brain, but the spinal cord receives sensory input and sends motor commands out to the body through the spinal nerves. Whereas the brain develops into a complex series of nuclei and fiber tracts, the spinal cord remains relatively simple in its configuration ([link](#)). From the initial neural tube early in embryonic development, the spinal cord retains a tube-like structure with gray matter surrounding the small central canal and white matter on the surface in three columns. The dorsal, or posterior, horns of the gray matter are mainly devoted to sensory functions whereas the ventral, or anterior, and lateral horns are associated with motor functions. In the white matter, the dorsal column relays sensory information to the brain, and the anterior column is almost exclusively relaying motor commands to the ventral horn motor neurons. The lateral column, however, conveys both sensory and motor information between the spinal cord and brain.

Locations of Spinal Fiber Tracts



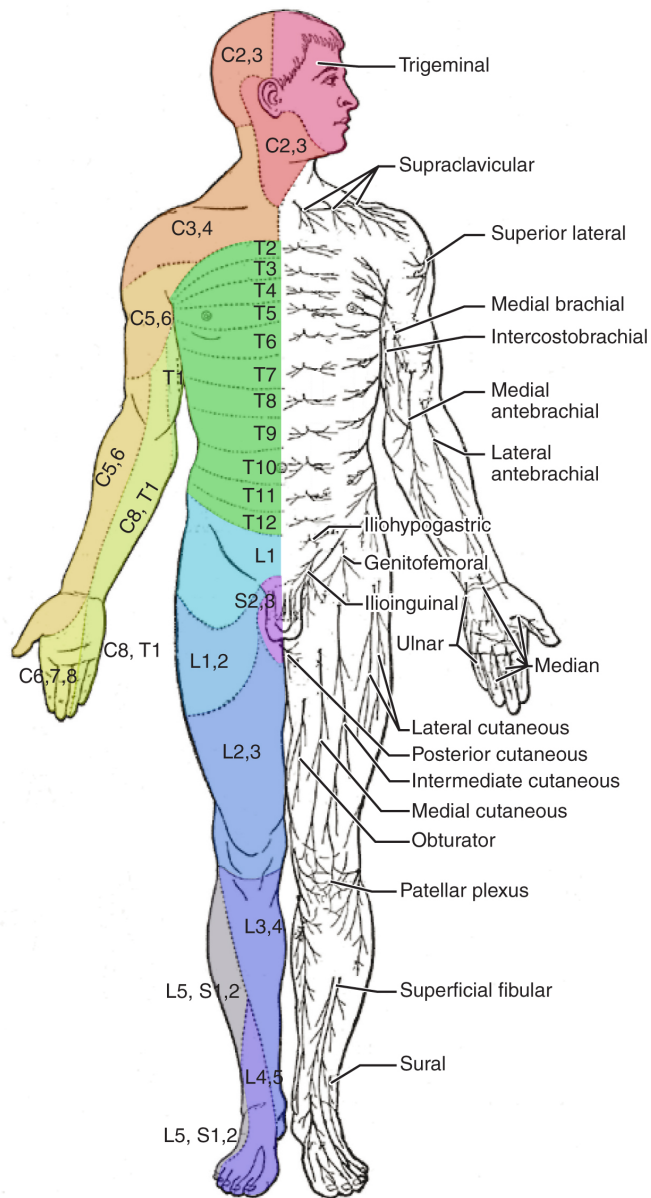
Sensory Modalities and Location

The general senses are distributed throughout the body, relying on nervous tissue incorporated into various organs. Somatic senses are incorporated mostly into the skin, muscles, or tendons, whereas the visceral senses come from nervous tissue incorporated into the majority of organs such as the heart or stomach. The somatic senses are those that usually make up the conscious perception of how the body interacts with the environment. The visceral senses are most often below the limit of conscious perception because they are involved in homeostatic regulation through the autonomic nervous system.

The sensory exam tests the somatic senses, meaning those that are consciously perceived. Testing of the senses begins with examining the regions known as dermatomes that connect to the cortical region where somatosensation is perceived in the postcentral gyrus. To test the sensory fields, a simple stimulus of the light touch of the soft end of a cotton-tipped

applicator is applied at various locations on the skin. The spinal nerves, which contain sensory fibers with dendritic endings in the skin, connect with the skin in a topographically organized manner, illustrated as dermatomes ([link](#)). For example, the fibers of eighth cervical nerve innervate the medial surface of the forearm and extend out to the fingers. In addition to testing perception at different positions on the skin, it is necessary to test sensory perception within the dermatome from distal to proximal locations in the appendages, or lateral to medial locations in the trunk. In testing the eighth cervical nerve, the patient would be asked if the touch of the cotton to the fingers or the medial forearm was perceptible, and whether there were any differences in the sensations.

Dermatomes



The surface of the skin can be divided into topographic regions that relate to the location of sensory endings in the skin based on the spinal nerve that contains those fibers. (credit: modification of work by Mikael Häggström)

Other modalities of somatosensation can be tested using a few simple tools. The perception of pain can be tested using the broken end of the cotton-tipped applicator. The perception of vibratory stimuli can be testing using an oscillating tuning fork placed against prominent bone features such as the distal head of the ulna on the medial aspect of the elbow. When the tuning fork is still, the metal against the skin can be perceived as a cold stimulus. Using the cotton tip of the applicator, or even just a fingertip, the perception of tactile movement can be assessed as the stimulus is drawn across the skin for approximately 2–3 cm. The patient would be asked in what direction the stimulus is moving. All of these tests are repeated in distal and proximal locations and for different dermatomes to assess the spatial specificity of perception. The sense of position and motion, proprioception, is tested by moving the fingers or toes and asking the patient if they sense the movement. If the distal locations are not perceived, the test is repeated at increasingly proximal joints.

The various stimuli used to test sensory input assess the function of the major ascending tracts of the spinal cord. The dorsal column pathway conveys fine touch, vibration, and proprioceptive information, whereas the spinothalamic pathway primarily conveys pain and temperature. Testing these stimuli provides information about whether these two major ascending pathways are functioning properly. Within the spinal cord, the two systems are segregated. The dorsal column information ascends ipsilateral to the source of the stimulus and decussates in the medulla, whereas the spinothalamic pathway decussates at the level of entry and ascends contralaterally. The differing sensory stimuli are segregated in the spinal cord so that the various subtests for these stimuli can distinguish which ascending pathway may be damaged in certain situations.

Whereas the basic sensory stimuli are assessed in the subtests directed at each submodality of somatosensation, testing the ability to discriminate sensations is important. Pairing the light touch and pain subtests together makes it possible to compare the two submodalities at the same time, and therefore the two major ascending tracts at the same time. Mistaking painful stimuli for light touch, or vice versa, may point to errors in ascending projections, such as in a **hemisection** of the spinal cord that might come from a motor vehicle accident.

Another issue of sensory discrimination is not distinguishing between different submodalities, but rather location. The two-point discrimination subtest highlights the density of sensory endings, and therefore receptive fields in the skin. The sensitivity to fine touch, which can give indications of the texture and detailed shape of objects, is highest in the fingertips. To assess the limit of this sensitivity, two-point discrimination is measured by simultaneously touching the skin in two locations, such as could be accomplished with a pair of forceps. Specialized calipers for precisely measuring the distance between points are also available. The patient is asked to indicate whether one or two stimuli are present while keeping their eyes closed. The examiner will switch between using the two points and a single point as the stimulus. Failure to recognize two points may be an indication of a dorsal column pathway deficit.

Similar to two-point discrimination, but assessing laterality of perception, is double simultaneous stimulation. Two stimuli, such as the cotton tips of two applicators, are touched to the same position on both sides of the body. If one side is not perceived, this may indicate damage to the contralateral posterior parietal lobe. Because there is one of each pathway on either side of the spinal cord, they are not likely to interact. If none of the other subtests suggest particular deficits with the pathways, the deficit is likely to be in the cortex where conscious perception is based. The mental status exam contains subtests that assess other functions that are primarily localized to the parietal cortex, such as stereognosis and graphesthesia.

A final subtest of sensory perception that concentrates on the sense of proprioception is known as the **Romberg test**. The patient is asked to stand straight with feet together. Once the patient has achieved their balance in that position, they are asked to close their eyes. Without visual feedback that the body is in a vertical orientation relative to the surrounding environment, the patient must rely on the proprioceptive stimuli of joint and muscle position, as well as information from the inner ear, to maintain balance. This test can indicate deficits in dorsal column pathway proprioception, as well as problems with proprioceptive projections to the cerebellum through the **spinocerebellar tract**.

Note:

Watch this [video](#) to see a quick demonstration of two-point discrimination. Touching a specialized caliper to the surface of the skin will measure the distance between two points that are perceived as distinct stimuli versus a single stimulus. The patient keeps their eyes closed while the examiner switches between using both points of the caliper or just one. The patient then must indicate whether one or two stimuli are in contact with the skin. Why is the distance between the caliper points closer on the fingertips as opposed to the palm of the hand? And what do you think the distance would be on the arm, or the shoulder?

Muscle Strength and Voluntary Movement

The skeletomotor system is largely based on the simple, two-cell projection from the precentral gyrus of the frontal lobe to the skeletal muscles. The corticospinal tract represents the neurons that send output from the primary motor cortex. These fibers travel through the deep white matter of the cerebrum, then through the midbrain and pons, into the medulla where most of them decussate, and finally through the spinal cord white matter in the lateral (crossed fibers) or anterior (uncrossed fibers) columns. These fibers synapse on motor neurons in the ventral horn. The ventral horn motor neurons then project to skeletal muscle and cause contraction. These two cells are termed the upper motor neuron (UMN) and the lower motor neuron (LMN). Voluntary movements require these two cells to be active.

The motor exam tests the function of these neurons and the muscles they control. First, the muscles are inspected and palpated for signs of structural irregularities. Movement disorders may be the result of changes to the

muscle tissue, such as scarring, and these possibilities need to be ruled out before testing function. Along with this inspection, muscle tone is assessed by moving the muscles through a passive range of motion. The arm is moved at the elbow and wrist, and the leg is moved at the knee and ankle. Skeletal muscle should have a resting tension representing a slight contraction of the fibers. The lack of muscle tone, known as **hypotonicity** or **flaccidity**, may indicate that the LMN is not conducting action potentials that will keep a basal level of acetylcholine in the neuromuscular junction.

If muscle tone is present, muscle strength is tested by having the patient contract muscles against resistance. The examiner will ask the patient to lift the arm, for example, while the examiner is pushing down on it. This is done for both limbs, including shrugging the shoulders. Lateral differences in strength—being able to push against resistance with the right arm but not the left—would indicate a deficit in one corticospinal tract versus the other. An overall loss of strength, without laterality, could indicate a global problem with the motor system. Diseases that result in UMN lesions include cerebral palsy or MS, or it may be the result of a stroke. A sign of UMN lesion is a negative result in the subtest for **pronator drift**. The patient is asked to extend both arms in front of the body with the palms facing up. While keeping the eyes closed, if the patient unconsciously allows one or the other arm to slowly relax, toward the pronated position, this could indicate a failure of the motor system to maintain the supinated position.

Reflexes

Reflexes combine the spinal sensory and motor components with a sensory input that directly generates a motor response. The reflexes that are tested in the neurological exam are classified into two groups. A **deep tendon reflex** is commonly known as a stretch reflex, and is elicited by a strong tap to a tendon, such as in the knee-jerk reflex. A **superficial reflex** is elicited through gentle stimulation of the skin and causes contraction of the associated muscles.

For the arm, the common reflexes to test are of the biceps, brachioradialis, triceps, and flexors for the digits. For the leg, the knee-jerk reflex of the

quadriceps is common, as is the ankle reflex for the gastrocnemius and soleus. The tendon at the insertion for each of these muscles is struck with a rubber mallet. The muscle is quickly stretched, resulting in activation of the muscle spindle that sends a signal into the spinal cord through the dorsal root. The fiber synapses directly on the ventral horn motor neuron that activates the muscle, causing contraction. The reflexes are physiologically useful for stability. If a muscle is stretched, it reflexively contracts to return the muscle to compensate for the change in length. In the context of the neurological exam, reflexes indicate that the LMN is functioning properly.

The most common superficial reflex in the neurological exam is the **plantar reflex** that tests for the **Babinski sign** on the basis of the extension or flexion of the toes at the plantar surface of the foot. The plantar reflex is commonly tested in newborn infants to establish the presence of neuromuscular function. To elicit this reflex, an examiner brushes a stimulus, usually the examiner's fingertip, along the plantar surface of the infant's foot. An infant would present a positive Babinski sign, meaning the foot dorsiflexes and the toes extend and splay out. As a person learns to walk, the plantar reflex changes to cause curling of the toes and a moderate plantar flexion. If superficial stimulation of the sole of the foot caused extension of the foot, keeping one's balance would be harder. The descending input of the corticospinal tract modifies the response of the plantar reflex, meaning that a negative Babinski sign is the expected response in testing the reflex. Other superficial reflexes are not commonly tested, though a series of abdominal reflexes can target function in the lower thoracic spinal segments.

Note:



Watch this [video](#) to see how to test reflexes in the abdomen. Testing reflexes of the trunk is not commonly performed in the neurological exam, but if findings suggest a problem with the thoracic segments of the spinal cord, a series of superficial reflexes of the abdomen can localize function to those segments. If contraction is not observed when the skin lateral to the umbilicus (belly button) is stimulated, what level of the spinal cord may be damaged?

Comparison of Upper and Lower Motor Neuron Damage

Many of the tests of motor function can indicate differences that will address whether damage to the motor system is in the upper or lower motor neurons. Signs that suggest a UMN lesion include muscle weakness, strong deep tendon reflexes, decreased control of movement or slowness, pronator drift, a positive Babinski sign, **spasticity**, and the **clasp-knife response**. Spasticity is an excess contraction in resistance to stretch. It can result in **hyperflexia**, which is when joints are overly flexed. The clasp-knife response occurs when the patient initially resists movement, but then releases, and the joint will quickly flex like a pocket knife closing.

A lesion on the LMN would result in paralysis, or at least partial loss of voluntary muscle control, which is known as **paresis**. The paralysis observed in LMN diseases is referred to as **flaccid paralysis**, referring to a complete or partial loss of muscle tone, in contrast to the loss of control in UMN lesions in which tone is retained and spasticity is exhibited. Other signs of an LMN lesion are **fibrillation**, **fasciculation**, and compromised or lost reflexes resulting from the denervation of the muscle fibers.

Note:

Disorders of the...

Spinal Cord

In certain situations, such as a motorcycle accident, only half of the spinal cord may be damaged in what is known as a hemisection. Forceful trauma to the trunk may cause ribs or vertebrae to fracture, and debris can crush or

section through part of the spinal cord. The full section of a spinal cord would result in paraplegia, or loss of voluntary motor control of the lower body, as well as loss of sensations from that point down. A hemisection, however, will leave spinal cord tracts intact on one side. The resulting condition would be hemiplegia on the side of the trauma—one leg would be paralyzed. The sensory results are more complicated.

The ascending tracts in the spinal cord are segregated between the dorsal column and spinothalamic pathways. This means that the sensory deficits will be based on the particular sensory information each pathway conveys. Sensory discrimination between touch and painful stimuli will illustrate the difference in how these pathways divide these functions.

On the paralyzed leg, a patient will acknowledge painful stimuli, but not fine touch or proprioceptive sensations. On the functional leg, the opposite is true. The reason for this is that the dorsal column pathway ascends ipsilateral to the sensation, so it would be damaged the same way as the lateral corticospinal tract. The spinothalamic pathway decussates immediately upon entering the spinal cord and ascends contralateral to the source; it would therefore bypass the hemisection.

The motor system can indicate the loss of input to the ventral horn in the lumbar enlargement where motor neurons to the leg are found, but motor function in the trunk is less clear. The left and right anterior corticospinal tracts are directly adjacent to each other. The likelihood of trauma to the spinal cord resulting in a hemisection that affects one anterior column, but not the other, is very unlikely. Either the axial musculature will not be affected at all, or there will be bilateral losses in the trunk.

Sensory discrimination can pinpoint the level of damage in the spinal cord. Below the hemisection, pain stimuli will be perceived in the damaged side, but not fine touch. The opposite is true on the other side. The pain fibers on the side with motor function cross the midline in the spinal cord and ascend in the contralateral lateral column as far as the hemisection. The dorsal column will be intact ipsilateral to the source on the intact side and reach the brain for conscious perception. The trauma would be at the level just before sensory discrimination returns to normal, helping to pinpoint the trauma. Whereas imaging technology, like magnetic resonance imaging (MRI) or computed tomography (CT) scanning, could localize the injury as well, nothing more complicated than a cotton-tipped applicator can localize

the damage. That may be all that is available on the scene when moving the victim requires crucial decisions be made.

Chapter Review

The sensory and motor exams assess function related to the spinal cord and the nerves connected to it. Sensory functions are associated with the dorsal regions of the spinal cord, whereas motor function is associated with the ventral side. Localizing damage to the spinal cord is related to assessments of the peripheral projections mapped to dermatomes.

Sensory tests address the various submodalities of the somatic senses: touch, temperature, vibration, pain, and proprioception. Results of the subtests can point to trauma in the spinal cord gray matter, white matter, or even in connections to the cerebral cortex.

Motor tests focus on the function of the muscles and the connections of the descending motor pathway. Muscle tone and strength are tested for upper and lower extremities. Input to the muscles comes from the descending cortical input of upper motor neurons and the direct innervation of lower motor neurons.

Reflexes can either be based on deep stimulation of tendons or superficial stimulation of the skin. The presence of reflexive contractions helps to differentiate motor disorders between the upper and lower motor neurons. The specific signs associated with motor disorders can establish the difference further, based on the type of paralysis, the state of muscle tone, and specific indicators such as pronator drift or the Babinski sign.

Interactive Link Questions

Exercise:

Problem:

Watch this [video](#) to see a quick demonstration of two-point discrimination. Touching a specialized caliper to the surface of the skin will measure the distance between two points that are perceived as distinct stimuli versus a single stimulus. The patient keeps their eyes closed while the examiner switches between using both points of the caliper or just one. The patient then must indicate whether one or two stimuli are in contact with the skin. Why is the distance between the caliper points closer on the fingertips as opposed to the palm of the hand? And what do you think the distance would be on the arm, or the shoulder?

Solution:

The fingertips are the most sensitive skin on the hand, so the points of the caliper can be closer together and still be recognized as two separate points. On the palm, the sensitivity is less, so the points need to be farther apart. This will continue on the arm and shoulder, as sensitivity decreases, the discrimination of separate stimuli will be wider.

Exercise:**Problem:**

Watch this [video](#) to see how to test reflexes in the abdomen. Testing reflexes of the trunk is not commonly performed in the neurological exam, but if findings suggest a problem with the thoracic segments of the spinal cord, a series of superficial reflexes of the abdomen can localize function to those segments. If contraction is not observed when the skin lateral to the umbilicus (belly button) is stimulated, what level of the spinal cord may be damaged?

Solution:

The region lateral to the umbilicus is innervated by T9–T11, approximately. A lack of contraction following that stimulation would

therefore suggest damage at those levels.

Review Questions

Exercise:

Problem:

Which of the following is *not* part of the corticospinal pathway?

- a. cerebellar deep white matter
- b. midbrain
- c. medulla
- d. lateral column

Solution:

A

Exercise:

Problem: Which subtest is directed at proprioceptive sensation?

- a. two-point discrimination
- b. tactile movement
- c. vibration
- d. Romberg test

Solution:

D

Exercise:

Problem:

What term describes the inability to lift the arm above the level of the shoulder?

- a. paralysis
- b. paresis
- c. fasciculation
- d. fibrillation

Solution:

B

Exercise:**Problem:**

Which type of reflex is the jaw-jerk reflex that is part of the cranial nerve exam for the vestibulocochlear nerve?

- a. visceral reflex
- b. withdrawal reflex
- c. stretch reflex
- d. superficial reflex

Solution:

C

Exercise:**Problem:**

Which of the following is a feature of both somatic and visceral senses?

- a. requires cerebral input

- b. causes skeletal muscle contraction
- c. projects to a ganglion near the target effector
- d. involves an axon in the ventral nerve root

Solution:

D

Critical Thinking Questions

Exercise:

Problem:

The location of somatosensation is based on the topographical map of sensory innervation. What does this mean?

Solution:

Where spinal nerves innervate the skin is represented by “slices” of the body surface referred to as dermatomes. The fibers originating in each region are contained within the same spinal nerve, which relates to the perception of that localization.

Exercise:

Problem:

Why are upper motor neuron lesions characterized by “spastic paralysis”?

Solution:

Paralysis means that voluntary muscle control is not possible because of the interruption of descending motor input. Spasticity refers to what could be called “hypercontractility” of the muscles in the absence of the descending input.

Glossary

Babinski sign

dorsiflexion of the foot with extension and splaying of the toes in response to the plantar reflex, normally suppressed by corticospinal input

clasp-knife response

sign of UMN disease when a patient initially resists passive movement of a muscle but will quickly release to a lower state of resistance

deep tendon reflex

another term for stretch reflex, based on the elicitation through deep stimulation of the tendon at the insertion

fasciculation

small muscle twitch as a result of spontaneous activity from an LMN

fibrillation

in motor responses, a spontaneous muscle action potential that occurs in the absence of neuromuscular input, resulting from LMN lesions

flaccid paralysis

loss of voluntary muscle control and muscle tone, as the result of LMN disease

flaccidity

presentation of a loss of muscle tone, observed as floppy limbs or a lack of resistance to passive movement

hemisection

cut through half of a structure, such as the spinal cord

hyperflexia

overly flexed joints

hypotonicity

low muscle tone, a sign of LMN disease

paresis

partial loss of, or impaired, voluntary muscle control

plantar reflex

superficial reflex initiated by gentle stimulation of the sole of the foot

pronator drift

sign of contralateral corticospinal lesion when the one arm will drift into a pronated position when held straight out with the palms facing upward

Romberg test

test of equilibrium that requires the patient to maintain a straight, upright posture without visual feedback of position

spasticity

increased contraction of a muscle in response to resistance, often resulting in hyperflexia

spinocerebellar tract

ascending fibers that carry proprioceptive input to the cerebellum used in maintaining balance and coordinated movement

superficial reflex

reflexive contraction initiated by gentle stimulation of the skin

The Coordination and Gait Exams

By the end of this section, you will be able to:

- Explain the relationship between the location of the cerebellum and its function in movement
- Chart the major divisions of the cerebellum
- List the major connections of the cerebellum
- Describe the relationship of the cerebellum to axial and appendicular musculature
- Explain the prevalent causes of cerebellar ataxia

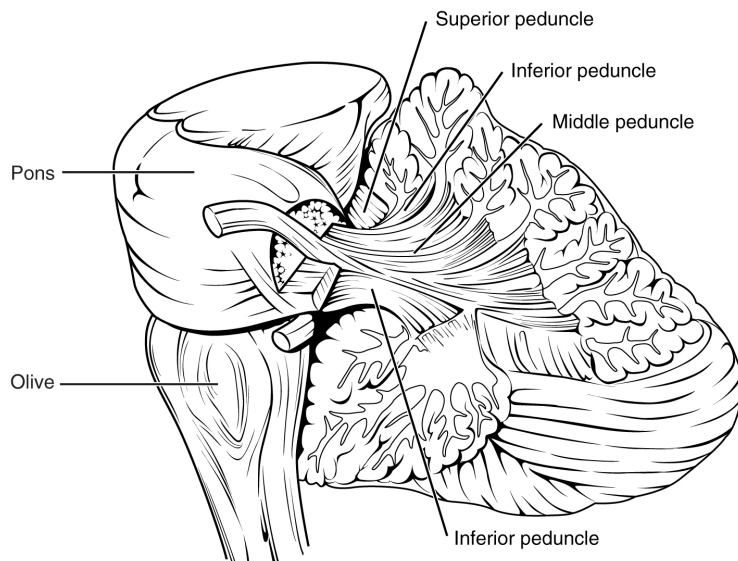
The role of the cerebellum is a subject of debate. There is an obvious connection to motor function based on the clinical implications of cerebellar damage. There is also strong evidence of the cerebellar role in procedural memory. The two are not incompatible; in fact, procedural memory is motor memory, such as learning to ride a bicycle. Significant work has been performed to describe the connections within the cerebellum that result in learning. A model for this learning is classical conditioning, as shown by the famous dogs from the physiologist Ivan Pavlov's work. This classical conditioning, which can be related to motor learning, fits with the neural connections of the cerebellum. The cerebellum is 10 percent of the mass of the brain and has varied functions that all point to a role in the motor system.

Location and Connections of the Cerebellum

The cerebellum is located in apposition to the dorsal surface of the brain stem, centered on the pons. The name of the pons is derived from its connection to the cerebellum. The word means "bridge" and refers to the thick bundle of myelinated axons that form a bulge on its ventral surface. Those fibers are axons that project from the gray matter of the pons into the contralateral cerebellar cortex. These fibers make up the **middle cerebellar peduncle (MCP)** and are the major physical connection of the cerebellum to the brain stem ([\[link\]](#)). Two other white matter bundles connect the cerebellum to the other regions of the brain stem. The **superior cerebellar peduncle (SCP)** is the connection of the cerebellum to the midbrain and

forebrain. The **inferior cerebellar peduncle (ICP)** is the connection to the medulla.

Cerebellar Peduncles



The connections to the cerebellum are the three cerebellar peduncles, which are close to each other. The ICP arises from the medulla—specifically from the inferior olive, which is visible as a bulge on the ventral surface of the brain stem.

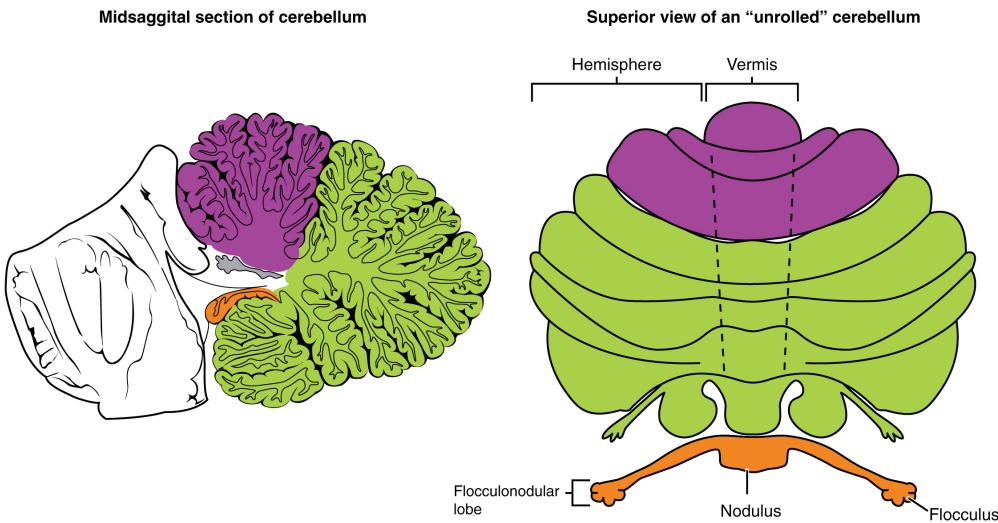
The MCP is the ventral surface of the pons. The SCP projects into the midbrain.

These connections can also be broadly described by their functions. The ICP conveys sensory input to the cerebellum, partially from the spinocerebellar tract, but also through fibers of the **inferior olive**. The MCP is part of the **cortico-ponto-cerebellar pathway** that connects the cerebral cortex with the cerebellum and preferentially targets the lateral regions of the cerebellum. It includes a copy of the motor commands sent from the precentral gyrus through the corticospinal tract, arising from collateral branches that synapse in the gray matter of the pons, along with input from other regions such as the visual cortex. The SCP is the major output of the

cerebellum, divided between the **red nucleus** in the midbrain and the thalamus, which will return cerebellar processing to the motor cortex. These connections describe a circuit that compares motor commands and sensory feedback to generate a new output. These comparisons make it possible to coordinate movements. If the cerebral cortex sends a motor command to initiate walking, that command is copied by the pons and sent into the cerebellum through the MCP. Sensory feedback in the form of proprioception from the spinal cord, as well as vestibular sensations from the inner ear, enters through the ICP. If you take a step and begin to slip on the floor because it is wet, the output from the cerebellum—through the SCP—can correct for that and keep you balanced and moving. The red nucleus sends new motor commands to the spinal cord through the **rubrospinal tract**.

The cerebellum is divided into regions that are based on the particular functions and connections involved. The midline regions of the cerebellum, the **vermis** and **flocculonodular lobe**, are involved in comparing visual information, equilibrium, and proprioceptive feedback to maintain balance and coordinate movements such as walking, or **gait**, through the descending output of the red nucleus ([\[link\]](#)). The lateral hemispheres are primarily concerned with planning motor functions through frontal lobe inputs that are returned through the thalamic projections back to the premotor and motor cortices. Processing in the midline regions targets movements of the axial musculature, whereas the lateral regions target movements of the appendicular musculature. The vermis is referred to as the **spinocerebellum** because it primarily receives input from the dorsal columns and spinocerebellar pathways. The flocculonodular lobe is referred to as the **vestibulocerebellum** because of the vestibular projection into that region. Finally, the lateral cerebellum is referred to as the **cerebrocerebellum**, reflecting the significant input from the cerebral cortex through the cortico-ponto-cerebellar pathway.

Major Regions of the Cerebellum



The cerebellum can be divided into two basic regions: the midline and the hemispheres. The midline is composed of the vermis and the flocculonodular lobe, and the hemispheres are the lateral regions.

Coordination and Alternating Movement

Testing for cerebellar function is the basis of the coordination exam. The subtests target appendicular musculature, controlling the limbs, and axial musculature for posture and gait. The assessment of cerebellar function will depend on the normal functioning of other systems addressed in previous sections of the neurological exam. Motor control from the cerebrum, as well as sensory input from somatic, visual, and vestibular senses, are important to cerebellar function.

The subtests that address appendicular musculature, and therefore the lateral regions of the cerebellum, begin with a check for tremor. The patient extends their arms in front of them and holds the position. The examiner watches for the presence of tremors that would not be present if the muscles are relaxed. By pushing down on the arms in this position, the examiner can check for the rebound response, which is when the arms are automatically brought back to the extended position. The extension of the arms is an

ongoing motor process, and the tap or push on the arms presents a change in the proprioceptive feedback. The cerebellum compares the cerebral motor command with the proprioceptive feedback and adjusts the descending input to correct. The red nucleus would send an additional signal to the LMN for the arm to increase contraction momentarily to overcome the change and regain the original position.

The **check reflex** depends on cerebellar input to keep increased contraction from continuing after the removal of resistance. The patient flexes the elbow against resistance from the examiner to extend the elbow. When the examiner releases the arm, the patient should be able to stop the increased contraction and keep the arm from moving. A similar response would be seen if you try to pick up a coffee mug that you believe to be full but turns out to be empty. Without checking the contraction, the mug would be thrown from the overexertion of the muscles expecting to lift a heavier object.

Several subtests of the cerebellum assess the ability to alternate movements, or switch between muscle groups that may be antagonistic to each other. In the finger-to-nose test, the patient touches their finger to the examiner's finger and then to their nose, and then back to the examiner's finger, and back to the nose. The examiner moves the target finger to assess a range of movements. A similar test for the lower extremities has the patient touch their toe to a moving target, such as the examiner's finger. Both of these tests involve flexion and extension around a joint—the elbow or the knee and the shoulder or hip—as well as movements of the wrist and ankle. The patient must switch between the opposing muscles, like the biceps and triceps brachii, to move their finger from the target to their nose.

Coordinating these movements involves the motor cortex communicating with the cerebellum through the pons and feedback through the thalamus to plan the movements. Visual cortex information is also part of the processing that occurs in the cerebrocerebellum while it is involved in guiding movements of the finger or toe.

Rapid, alternating movements are tested for the upper and lower extremities. The patient is asked to touch each finger to their thumb, or to pat the palm of one hand on the back of the other, and then flip that hand

over and alternate back-and-forth. To test similar function in the lower extremities, the patient touches their heel to their shin near the knee and slides it down toward the ankle, and then back again, repetitively. Rapid, alternating movements are part of speech as well. A patient is asked to repeat the nonsense consonants “lah-kah-pah” to alternate movements of the tongue, lips, and palate. All of these rapid alternations require planning from the cerebrocerebellum to coordinate movement commands that control the coordination.

Posture and Gait

Gait can either be considered a separate part of the neurological exam or a subtest of the coordination exam that addresses walking and balance. Testing posture and gait addresses functions of the spinocerebellum and the vestibulocerebellum because both are part of these activities. A subtest called station begins with the patient standing in a normal position to check for the placement of the feet and balance. The patient is asked to hop on one foot to assess the ability to maintain balance and posture during movement. Though the station subtest appears to be similar to the Romberg test, the difference is that the patient’s eyes are open during station. The Romberg test has the patient stand still with the eyes closed. Any changes in posture would be the result of proprioceptive deficits, and the patient is able to recover when they open their eyes.

Subtests of walking begin with having the patient walk normally for a distance away from the examiner, and then turn and return to the starting position. The examiner watches for abnormal placement of the feet and the movement of the arms relative to the movement. The patient is then asked to walk with a few different variations. Tandem gait is when the patient places the heel of one foot against the toe of the other foot and walks in a straight line in that manner. Walking only on the heels or only on the toes will test additional aspects of balance.

Ataxia

A movement disorder of the cerebellum is referred to as **ataxia**. It presents as a loss of coordination in voluntary movements. Ataxia can also refer to

sensory deficits that cause balance problems, primarily in proprioception and equilibrium. When the problem is observed in movement, it is ascribed to cerebellar damage. Sensory and vestibular ataxia would likely also present with problems in gait and station.

Ataxia is often the result of exposure to exogenous substances, focal lesions, or a genetic disorder. Focal lesions include strokes affecting the cerebellar arteries, tumors that may impinge on the cerebellum, trauma to the back of the head and neck, or MS. Alcohol intoxication or drugs such as ketamine cause ataxia, but it is often reversible. Mercury in fish can cause ataxia as well. Hereditary conditions can lead to degeneration of the cerebellum or spinal cord, as well as malformation of the brain, or the abnormal accumulation of copper seen in Wilson's disease.

Note:



Watch this short [video](#) to see a test for station. Station refers to the position a person adopts when they are standing still. The examiner would look for issues with balance, which coordinates proprioceptive, vestibular, and visual information in the cerebellum. To test the ability of a subject to maintain balance, asking them to stand or hop on one foot can be more demanding. The examiner may also push the subject to see if they can maintain balance. An abnormal finding in the test of station is if the feet are placed far apart. Why would a wide stance suggest problems with cerebellar function?

Note:

Everyday Connections

The Field Sobriety Test

The neurological exam has been described as a clinical tool throughout this chapter. It is also useful in other ways. A variation of the coordination exam is the Field Sobriety Test (FST) used to assess whether drivers are under the influence of alcohol. The cerebellum is crucial for coordinated movements such as keeping balance while walking, or moving appendicular musculature on the basis of proprioceptive feedback. The cerebellum is also very sensitive to ethanol, the particular type of alcohol found in beer, wine, and liquor.

Walking in a straight line involves comparing the motor command from the primary motor cortex to the proprioceptive and vestibular sensory feedback, as well as following the visual guide of the white line on the side of the road. When the cerebellum is compromised by alcohol, the cerebellum cannot coordinate these movements effectively, and maintaining balance becomes difficult.

Another common aspect of the FST is to have the driver extend their arms out wide and touch their fingertip to their nose, usually with their eyes closed. The point of this is to remove the visual feedback for the movement and force the driver to rely just on proprioceptive information about the movement and position of their fingertip relative to their nose. With eyes open, the corrections to the movement of the arm might be so small as to be hard to see, but proprioceptive feedback is not as immediate and broader movements of the arm will probably be needed, particularly if the cerebellum is affected by alcohol.

Reciting the alphabet backwards is not always a component of the FST, but its relationship to neurological function is interesting. There is a cognitive aspect to remembering how the alphabet goes and how to recite it backwards. That is actually a variation of the mental status subtest of repeating the months backwards. However, the cerebellum is important because speech production is a coordinated activity. The speech rapid alternating movement subtest is specifically using the consonant changes of “lah-kah-pah” to assess coordinated movements of the lips, tongue, pharynx, and palate. But the entire alphabet, especially in the nonrehearsed backwards order, pushes this type of coordinated movement quite far. It is related to the reason that speech becomes slurred when a person is intoxicated.

Chapter Review

The cerebellum is an important part of motor function in the nervous system. It apparently plays a role in procedural learning, which would include motor skills such as riding a bike or throwing a football. The basis for these roles is likely to be tied into the role the cerebellum plays as a comparator for voluntary movement.

The motor commands from the cerebral hemispheres travel along the corticospinal pathway, which passes through the pons. Collateral branches of these fibers synapse on neurons in the pons, which then project into the cerebellar cortex through the middle cerebellar peduncles. Ascending sensory feedback, entering through the inferior cerebellar peduncles, provides information about motor performance. The cerebellar cortex compares the command to the actual performance and can adjust the descending input to compensate for any mismatch. The output from deep cerebellar nuclei projects through the superior cerebellar peduncles to initiate descending signals from the red nucleus to the spinal cord.

The primary role of the cerebellum in relation to the spinal cord is through the spinocerebellum; it controls posture and gait with significant input from the vestibular system. Deficits in cerebellar function result in ataxias, or a specific kind of movement disorder. The root cause of the ataxia may be the sensory input—either the proprioceptive input from the spinal cord or the equilibrium input from the vestibular system, or direct damage to the cerebellum by stroke, trauma, hereditary factors, or toxins.

Interactive Link Questions

Exercise:

Problem:

Watch this short [video](#) to see a test for station. Station refers to the position a person adopts when they are standing still. The examiner would look for issues with balance, which coordinates proprioceptive, vestibular, and visual information in the cerebellum. To test the ability of a subject to maintain balance, asking them to stand or hop on one foot can be more demanding. The examiner may also push the subject to see if they can maintain balance. An abnormal finding in the test of station is if the feet are placed far apart. Why would a wide stance suggest problems with cerebellar function?

Solution:

A wide stance would suggest the person needs to maintain balance by broadening their base. Instead of continuous correction to posture, this can keep the body stable when the cerebellum cannot.

Review Questions**Exercise:****Problem:**

Which white matter structure carries information from the cerebral cortex to the cerebellum?

- a. cerebral peduncle
 - b. superior cerebellar peduncle
 - c. middle cerebellar peduncle
 - d. inferior cerebellar peduncle
-

Solution:

C

Exercise:

Problem:

Which region of the cerebellum receives proprioceptive input from the spinal cord?

- a. vermis
 - b. left hemisphere
 - c. flocculonodular lobe
 - d. right hemisphere
-

Solution:

A

Exercise:**Problem:**

Which of the following tests cerebellar function related to gait?

- a. toe-to-finger
 - b. station
 - c. lah-kah-pah
 - d. finger-to-nose
-

Solution:

B

Exercise:

Problem: Which of the following is *not* a cause of cerebellar ataxia?

- a. mercury from fish
- b. drinking alcohol
- c. antibiotics
- d. hereditary degeneration of the cerebellum

Solution:

C

Exercise:**Problem:**

Which of the following functions *cannot* be attributed to the cerebellum?

- a. comparing motor commands and sensory feedback
- b. associating sensory stimuli with learned behavior
- c. coordinating complex movements
- d. processing visual information

Solution:

D

Critical Thinking Questions**Exercise:****Problem:**

Learning to ride a bike is a motor function dependent on the cerebellum. Why are the different regions of the cerebellum involved in this complex motor learning?

Solution:

The spinocerebellum is related to controlling the axial muscles and keeps the body balanced on the bike. The cerebrocerebellum is related to controlling the appendicular muscles and keeps the legs moving to pedal the bike. The vestibulocerebellum receives input about

equilibrium to help keep everything balanced as the bike is moving forward.

Exercise:

Problem:

Alcohol intoxication can produce slurred speech. How is this related to cerebellar function?

Solution:

Rapid alternating movements in speech relate to how the lips, tongue, and palate move to produce speech sounds. The cerebrocerebellum is required for the proper implementation of these movements.

Glossary

ataxia

movement disorder related to damage of the cerebellum characterized by loss of coordination in voluntary movements

cerebrocerebellum

lateral regions of the cerebellum; named for the significant input from the cerebral cortex

check reflex

response to a release in resistance so that the contractions stop, or check, movement

cortico-ponto-cerebellar pathway

projection from the cerebral cortex to the cerebellum by way of the gray matter of the pons

flocculonodular lobe

lobe of the cerebellum that receives input from the vestibular system to help with balance and posture

gait

rhythmic pattern of alternating movements of the lower limbs during locomotion

inferior cerebellar peduncle (ICP)

input to the cerebellum, largely from the inferior olive, that represents sensory feedback from the periphery

inferior olive

large nucleus in the medulla that receives input from sensory systems and projects into the cerebellar cortex

middle cerebellar peduncle (MCP)

large, white-matter bridge from the pons that constitutes the major input to the cerebellar cortex

red nucleus

nucleus in the midbrain that receives output from the cerebellum and projects onto the spinal cord in the rubrospinal tract

rubrospinal tract

descending tract from the red nucleus of the midbrain that results in modification of ongoing motor programs

spinocerebellum

midline region of the cerebellum known as the vermis that receives proprioceptive input from the spinal cord

superior cerebellar peduncle (SCP)

white-matter tract representing output of the cerebellum to the red nucleus of the midbrain

vermis

prominent ridge along the midline of the cerebellum that is referred to as the spinocerebellum

vestibulocerebellum

flocculonodular lobe of the cerebellum named for the vestibular input from the eighth cranial nerve